Description of San Bernardino County

San Bernardino County has had a long and colorful history. Paleo-Indian sites dating from c. 10,000 BC show that the area has been inhabited for at least 12,000 years. In the past three thousand years various Indian tribes flourished in the area: the Gabrielenos, the Serranos, the Vanyumes, the Mohave and the Chemehuevi.

The first explorers to enter the area were Pedro Fages, Military Commander of California, in 1772 and Fr. Francisco Garces, a missionary priest, in 1774. On May 20, 1810, Franciscan missionary Francisco Dumatz, of the San Gabriel Mission, led his company into the valley.

In observance of the feast day of St. Bernardine of Sienna, Father Dumatz named the valley San Bernardino. This name was later given to the nearby mountain range, and later the city and County.

In 1842 the Lugo family was granted Rancho San Bernardino, a holding of 37,700 acres encompassing the entire San Bernardino Valley. Captain Jefferson Hunt, of the Mormon Battalion, led a group of settlers into San Bernardino and in 1851 the Mormon Colony purchased the Rancho from the Lugo's.

In 1850 California was admitted into the United States. On April 26, 1853, San Bernardino County was created from parts of Los Angeles, San Diego and Mariposa Counties and in 1854 the city of San Bernardino was incorporated as the County seat. In 1860 gold was discovered in Holcomb and Bear Valleys in the San Bernardino Mountains, and placer mining began in Lytle Creek. Silver was being mined at Ivanpah in 1870, and the rich silver mines of the Calico district were developed in the 1880s. Borax was first discovered in 1761 in the Searles Dry Lake area near Trona, and transported out by twelve-, eighteen-or twenty-mule team wagons.

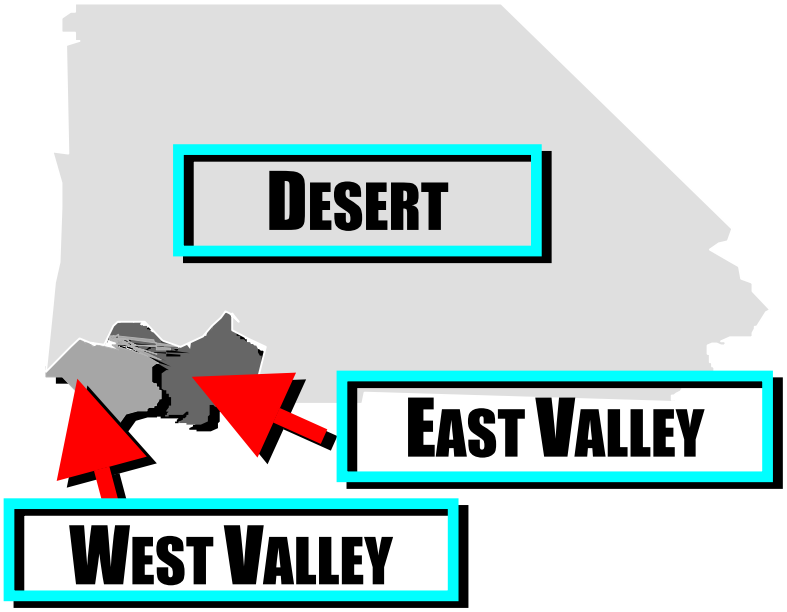
In 1857 three orange trees were planted on a farm in Old San Bernardino; by 1882 a rail car load of oranges and lemons grown in the East Valley was being shipped to Denver. As early as the 1840's vineyards were planted in the Cucamonga area and in the 1870 census San Bernardino County was credited with producing 48,720 gallons of wine.

San Bernardino County covers 20,160 square miles, and is the largest County in the contiguous United States. For example, the states of Massachusetts, Delaware, Rhode Islands and New Jersey combined fit within the boundaries of San Bernardino County. What does this mean in real teams? For instance, a person traveling from Needles, a small town located on the Colorado River, at the Eastern border of the County which abuts Nevada, will cover 231 ground miles and drive 4½ hours to reach the city of San Bernardino.

Because of its enormous size, diversity of population and geography, San Bernardino County presents some special problems when planning for services. Over three-quarters of the population lives on the southeastern valley portion of the County. The remainder of the population lives in the vast stretches of deserts and mountains that are studded with small and sometimes isolated communities. Subzero temperatures during the winter months in the mountain areas and temperatures in excess of 120 degrees in the desert areas present some critical problems for planning services particularly for elderly on fixed incomes.

SAN BERNARDINO COUNTY HAS A LONG AND COLORFUL HISTORY. PALEO-INDIAN SITES DATING FROM 10,000 BC SHOW THAT THE AREA HAS BEEN INHABITED FOR A LEAST 12, 000 YEARS.

DEPARTMENT OF AGING AND ADULT SERVICES
REGIONAL PLANNING AREAS MAP



For display purposes, East and West Valley are shown larger than they are on a map of the County.

The map displays the Department of Aging and Adult Services (DAAS) Planning Regions. Each region varies in population and landmass. For example, the North Desert located in the Desert Region is the largest subdivision within the region, with a landmass of 10,989.2 square miles and the West Valley Region is the smallest with a landmass of 200.9 square miles. Most of the population lives in the East and West Valley portion of the County. Otherwise, 75% of the population lives on 2% of the landmass and conversely 25% of the population lives on 98% of the landmass.

Because of this range in climate, diversity in life styles, and population distribution it has been imperative for DAAS to work with local community leaders to coordinate and develop services. Two volunteer groups who provide DAAS with invaluable community input are the Senior Affairs Commission and the Regional Councils on Aging. The Senior Affairs Commission, established by the Board of Supervisors on July 2, 1973, consists of seniors who are residents of the County. In order to increase regional representation giving voice to local concerns the Commission was increased from 16 to 30 representatives.

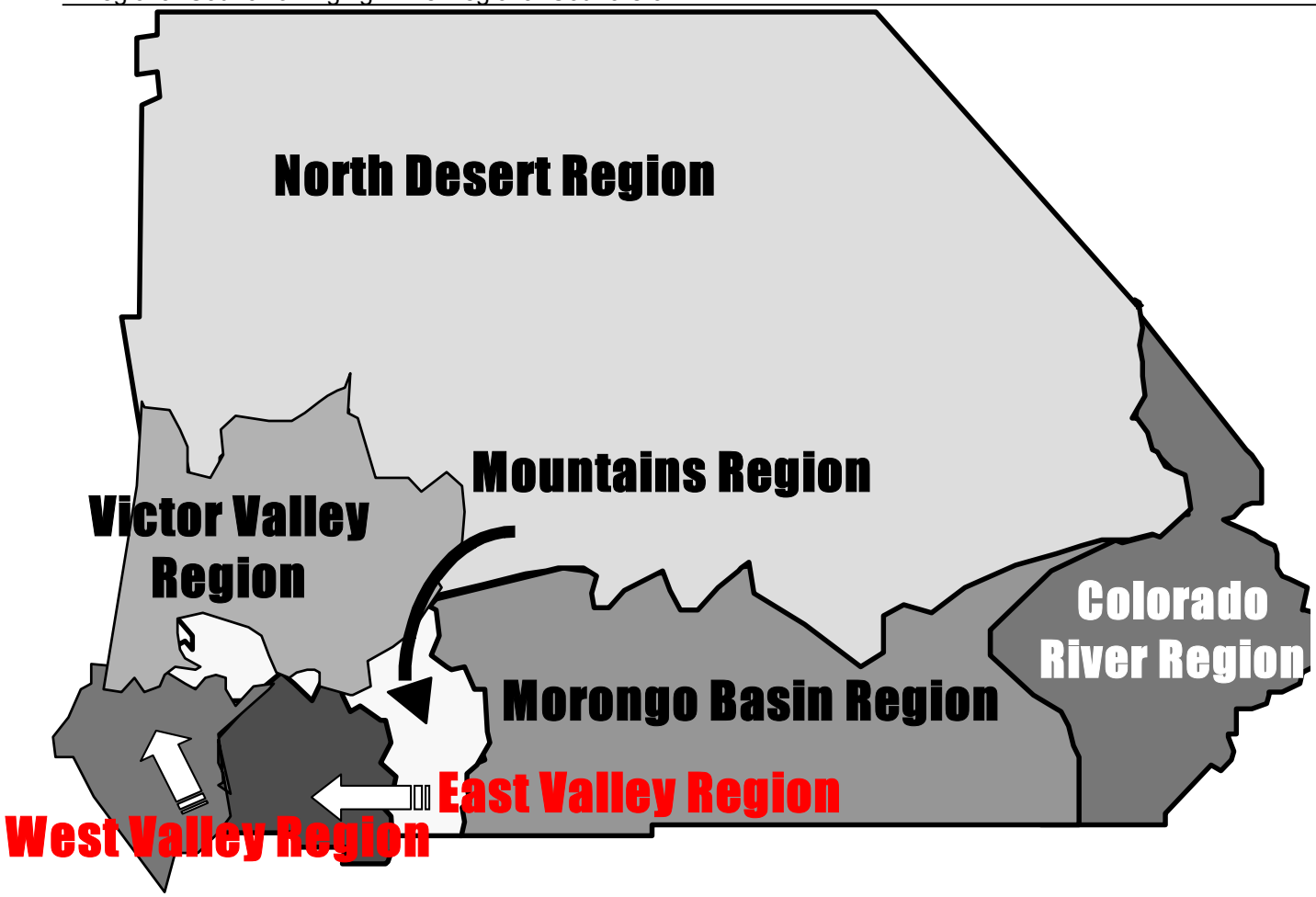
Membership on the Commission is comprised of:

- Four elected California Senior Legislators.
- One Silver-Haired Congress member.
- Six Nutrition Project Appointees. *(Seniors who are appointed by the Nutrition Programs to represent the seniors eating at the 40+ congregate nutrition sites throughout the County)*
- Six Board of Supervisor Appointees. *(Seniors who are appointed by the Supervisor of their district to represent senior concerns)*
- Six Commission Selected Members. *(Seniors who are selected by the members of SAC.)*
- Seven Regional Council on Aging Adult Services Chairpersons or their representatives. *(Seniors who are recruited from each region to chair the Regional Council on Aging)*

The Regional Councils on Aging were established in 1978 as an extension of the Area Agency on Aging for gathering the concerns of seniors in their local communities. The boundaries of each region were established along geographic, economic and political subdivisions borrowing heavily upon the service boundaries established by the Department of Public Social Services and the Regional Statistics Areas, RSA's established by the U.S. Bureau of the Census.

Within each area, seniors elect members to the Regional Council on Aging. The Regional Councils on Aging referred to as RCA's will be changing their name to reflect a broadening of the scope of service that DAAS is undertaking.

The new name is the Regional Councils on Aging and Adult Services and will provide the elderly and younger disabled adults within these communities a voice in the decision making process, and enable DAAS to keep abreast with the needs of the elderly and disabled adults within these regions.



Through the Senior Affairs Commission and the Regional Councils on Aging and Adult Services, DAAS has been able to refine its process of needs assessment and resource identification. These volunteer organizations serve to involve the senior citizens and disable adults of their region in determining service needs, in identifying the organizations best suited to perform these services, and in keeping the Department alert to the issues and concerns of seniors and disabled adults throughout the County.

While most of California has experienced an upward economic trend the city of San Bernardino to a large extent and the County as a whole has been slow to experience the same benefits. Closure of two military bases, one located in San Bernardino and the other in Victorville, caused widespread economic problems that until recently mired the County in a lagging economic recovery. This, coupled with the recent hikes in electric and natural gas costs has DAAS concerned for the elderly and younger dependent adults living on fixed incomes. Estimates from as low as 9% to as high as 200 and 300% or greater per month have been quoted by seniors particularly those living in the north desert communities of Barstow, Hinkley, Newberry Springs etc. As one elderly women stated, "It's a sad day when you have to choose between eating or staying warm…..sometimes eating wins."

Changing Trends and Challenges for the Future-*Demographic Profile*

The following pages contain tables prepared from two reports by the California Department of Finance. The first report highlights potential increases in the minority senior population and the second report provides information by age cohort for predicted growth for the entire population during the next 40 years.[1] Changes in population size and composition greatly influence many of our nation's policies and programs. From 1995 to 2005, persons reaching age 65 will be those born during the 1930's Depression era. As a result, the growth rate of the population aged 65 and over will be relatively modest during the next ten years. When persons born from 1946 to 1964, commonly known as the Baby-Boom generation, begin turning age 60 in 2006, we will start to witness a rapid growth rate of persons 60 and over. Unlike the uncertainty associated with many projections, "inevitability" is a term that characterizes this coming rapid growth. The reports project that the senior population will experience a sharp increase when the Baby-Boomers reach 60, and that the fastest growing age group within the senior population will be those individuals over the age of 75.

On the basis of the middle series of the Bureau of the Census population projections released in 1999, we can anticipate a moderate increase in the elderly population until about 2006, then a rapid increase for the next 20+ years to 2030. Similar projections prepared by the Social Security Administration (SSA) support these figures (SSA, 1999).

During the period from 1980 through 1990, the senior population grew from 124,868 to 170,432, for a total increase of 36%. Elderly population projections for the year 2000 are 199,097, for the year 2010 are 292,479 and by the year 2020 are expected to be 439,949, or by 2020 one out of every five people in San Bernardino County will be over the age of 65.

Many areas of public life will be greatly affected by the aging of the Baby-Boomers. The Baby-Boomers, the very large numbers of children born between 1946 and 1964, begin to turn age 60 about 2006 and age 65 about 2011.

What can the elderly expect for the future? The changing characteristics of the elderly, together with the uncertain social, economic, political, and scientific changes that lie ahead, make an accurate portrayal of the elderly population profile of tomorrow problematic.

We do know that the characteristics of the elderly population of the future are likely to be very different than those of today's elderly population. For instance, educational attainment levels of the elderly in the 21st century will be higher than those of the 20th century.

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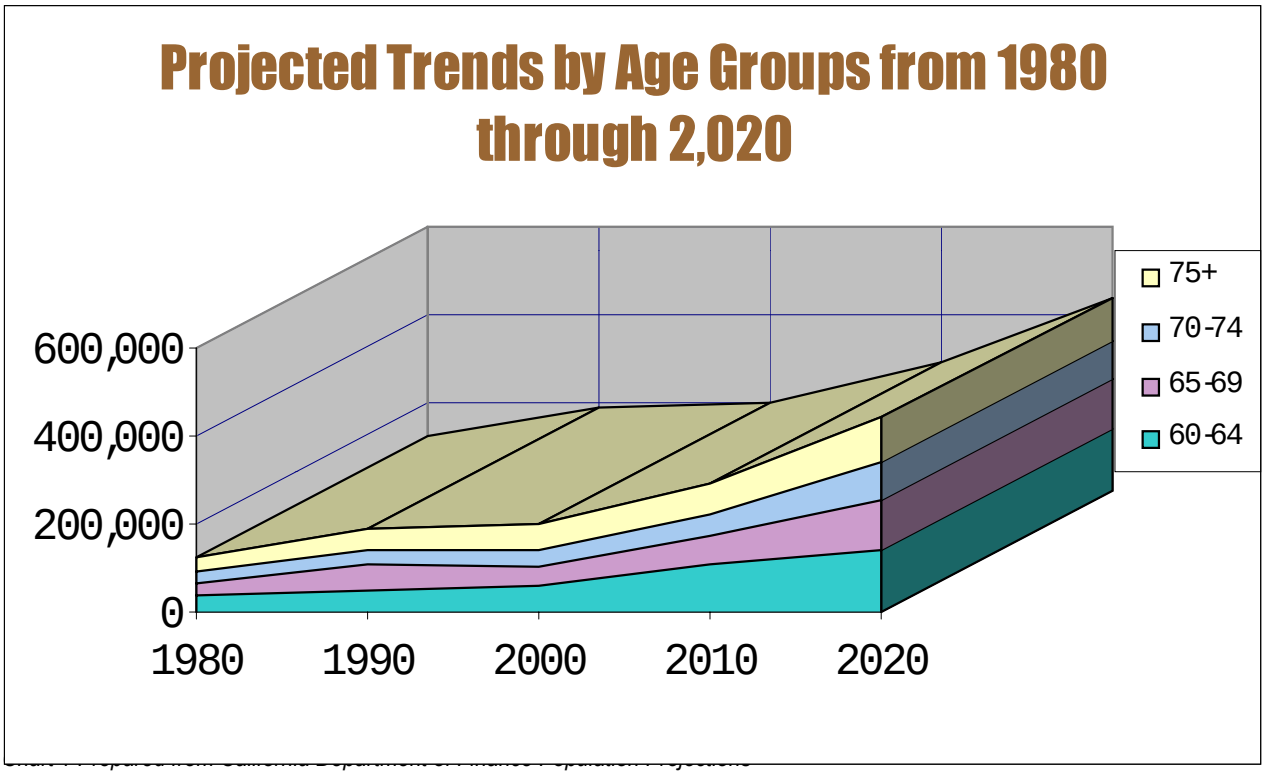
[1] *Highlights and corrections to the 1990 census data are presented as table A-1 through A-28 Other Tables depicted in this section are compiled from 1990 Census STF-1 & 3 files and Department of Finance Population Projections*

One might conclude, for example, that the future population explosion of the elderly would result in an expanding number of stereotypically frail and dependent persons and place a serious burden on society.



However, given the dynamic nature of changes affecting the future quality of our lives, alternate conclusions might be drawn.

As scientists increase the body of knowledge about biological mechanisms that control the aging process, a reduction in the severity of illness and disability may lead to a reduced demand on our health resources. Older Americans can expect to live more years and lives that are healthier longer.

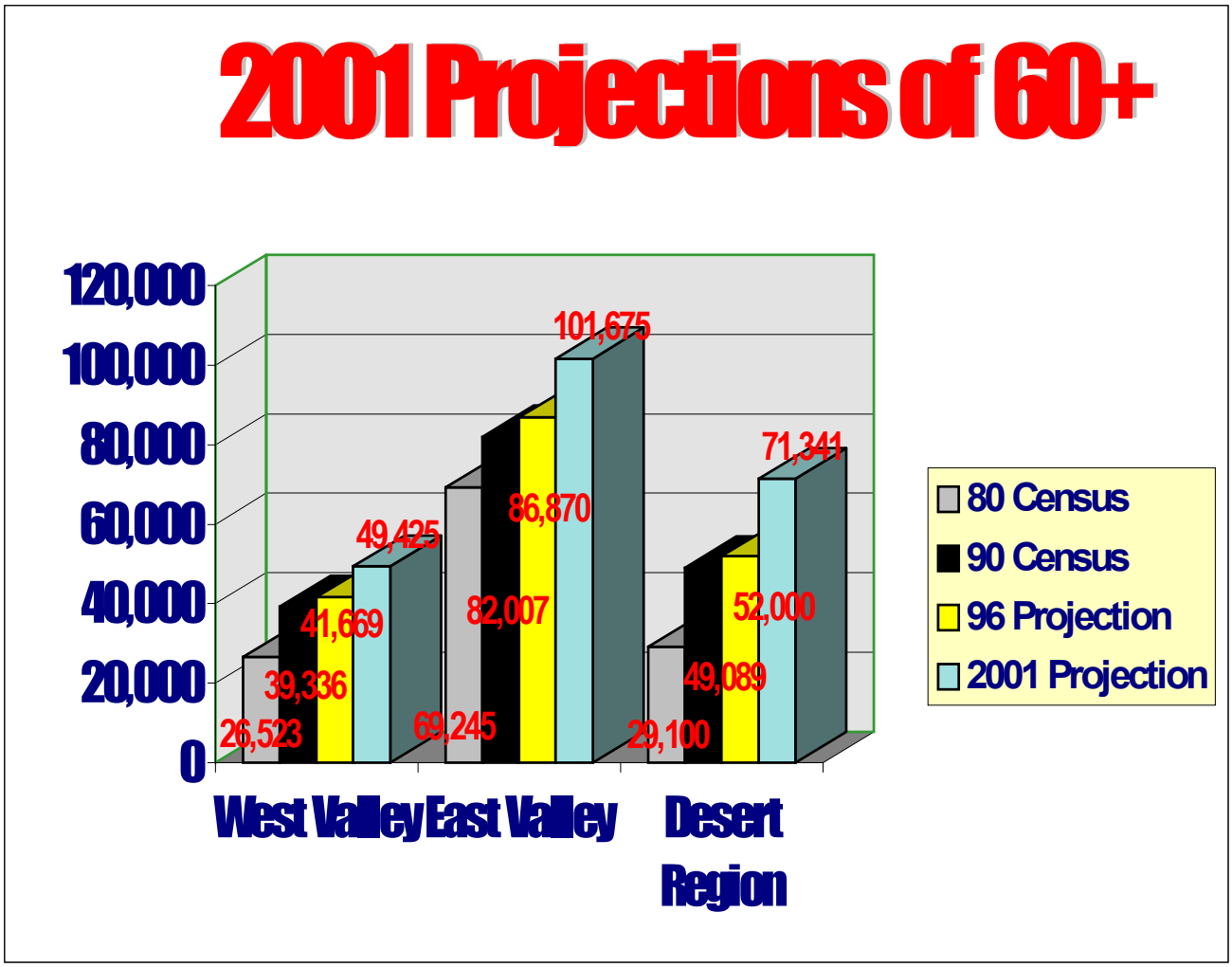
At the same time, two important challenges are: "how to maintain the quality of life with advancing age and how to produce cost-effective health care."[2] The current concern about the aging of our population arises from three new elements, linked closely to one another. The first is that the proportion of elderly in the total population is now substantial (13 percent).

The second is that the number of elderly and the rate of aging are expected to increase sharply, with implications for a vast increase in the numbers of persons requiring special services (health, recreation, housing, nutrition, social); participating in various entitlement programs; and requiring formal and informal care.

The third is recognition of the possible implications of an aging society for the whole range of our social institutions, from education and family to business and government.

[2] *National Institute on Aging, Older Americans Can Expect to Live Longer and Healthier Lives, Special Report on Aging 1993, Discoveries in Health for Aging Americans, 1993.*

Demographers have called out an early warning that the Baby-Boomer generation is approaching the elderly ranks. American society has tried to adjust to the size and needs of the Baby-Boomer generation throughout the stages of the life cycle. Just as this generation had an impact on the educational system (with "split shift" schools and youth in college) and the labor force (with job market pressures), the Baby-Boomer cohorts will place tremendous strain on the myriad specialized services and programs required of *Chart 2-1990 Census Summary Tape File (STF) 1 1980 & 1990 and projections for 1997 and 2000 prepared from the Department of Finance population projections*



an elderly population. A "window of opportunity" now exists for planners and policy makers to prepare for the aging of the Baby-Boomer generation.

How we respond to this age shift in the population (commonly referred to as the "Graying of America") will, to a large degree, depend on how successfully we are in amassing our resources and directing them toward developing an integrated system of services aimed at caring for the elderly. A system that provides a wide range of services to seniors and disabled adults in need of care while assuring choice, independence, quality of life, promoting the least restrictive environment while promoting aging in place is imperative if we are to move progressively at the beginning of this century.

County of San Bernardino Population Statistics – 1990 + Projections

As can be observed from the last two decades, the County's seniors are living longer with the fastest growing age cohort those 65 and over. As revealed in the 1990 census, the age cohorts experiencing the largest rates of growth from 1980 to 1990, were the 65-69 age group with an increase of 46.64%, and those individuals 75 and over with an increase of 43.21%. This is consistent with the National figures as well.

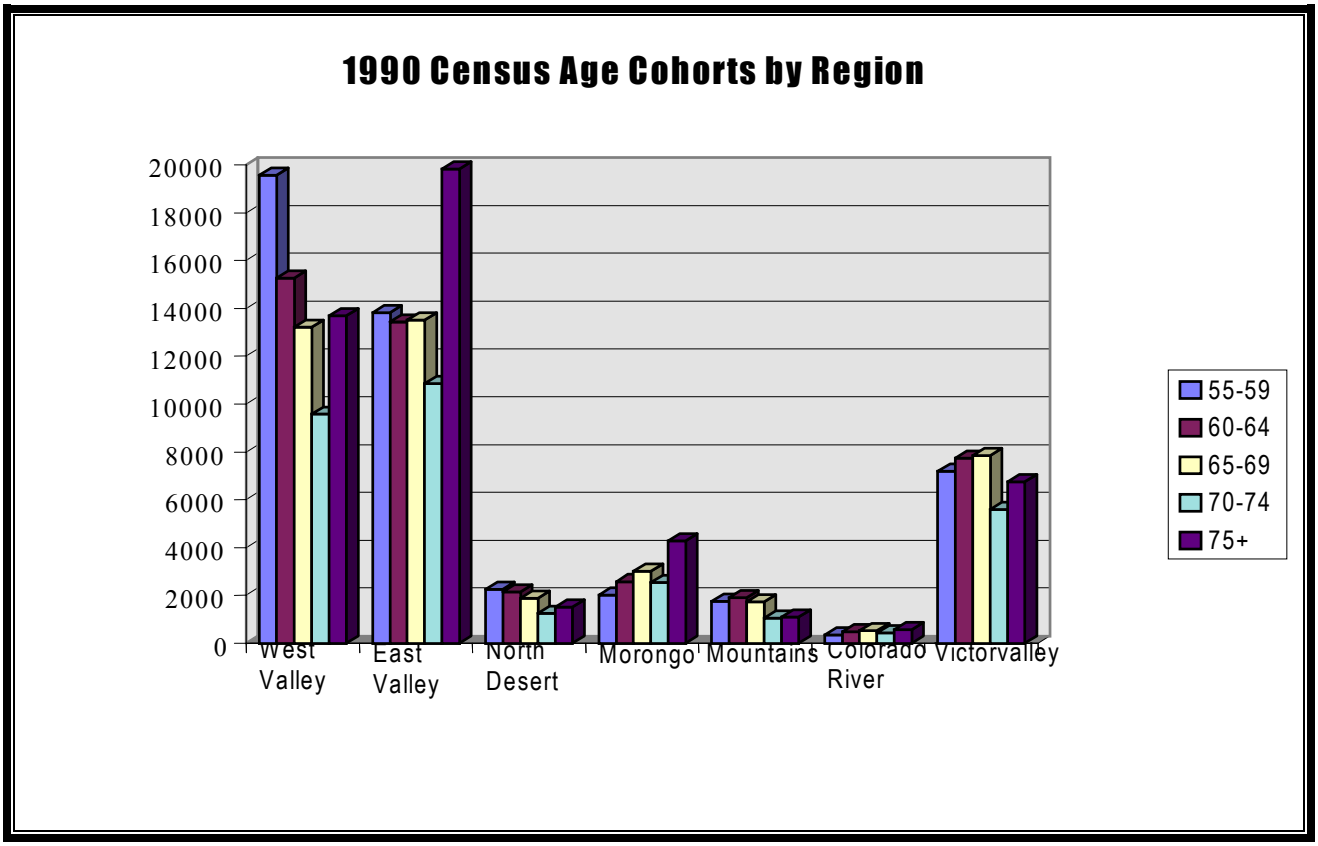


Chart-3 1990 Census STF-1 Age Cohorts by Tracts

Certain cities within each of the regions have displayed increased growth within certain age cohorts. For example, the East Valley Region, highly metropolitan, has experienced an increase in the percentage of seniors over 75 within the city of San Bernardino. This is not due to migration of seniors into the city, but rather points to migration of the younger population moving from the city to other less congested areas. The population that has remained is most often the low-income families and older individuals less mobile and less able to relocate. Many of the older individuals own their homes and are on fixed incomes. As the neighborhoods in which they live have declined, they find themselves in homes that are in need of repairs, which they cannot afford, and in areas that have increasingly high crime rates.

East Valley 1990 Census Age Cohorts

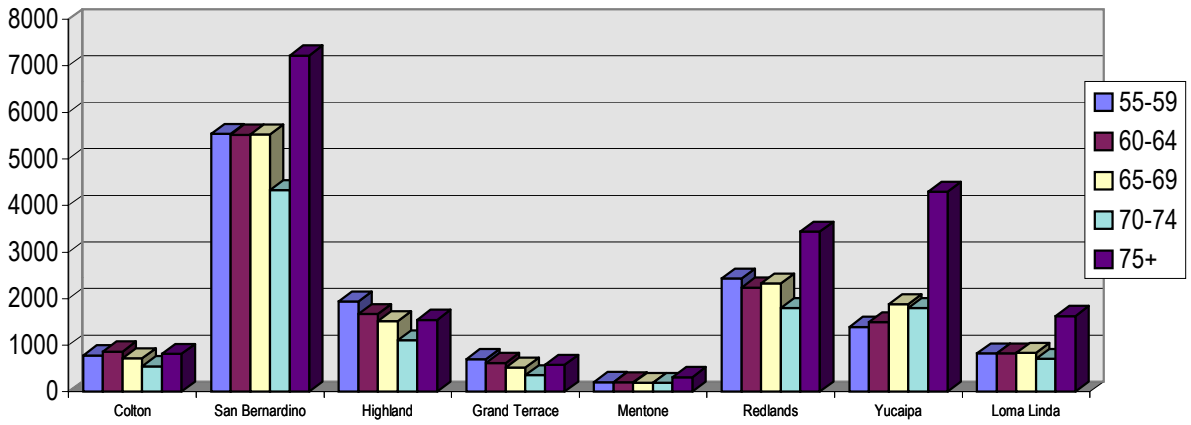


Chart 4-1990 Census Age Cohorts by Census Tracts

Two other cities with large 75+ populations are Redlands and Yucaipa. Both cities have traditionally had large senior populations; in fact, Yucaipa has the largest senior population per capita in the County. Most of the 75+ populations in these two cities are long time residents rather than people who have recently moved after retirement.

West Valley 1990 Census Age Cohorts

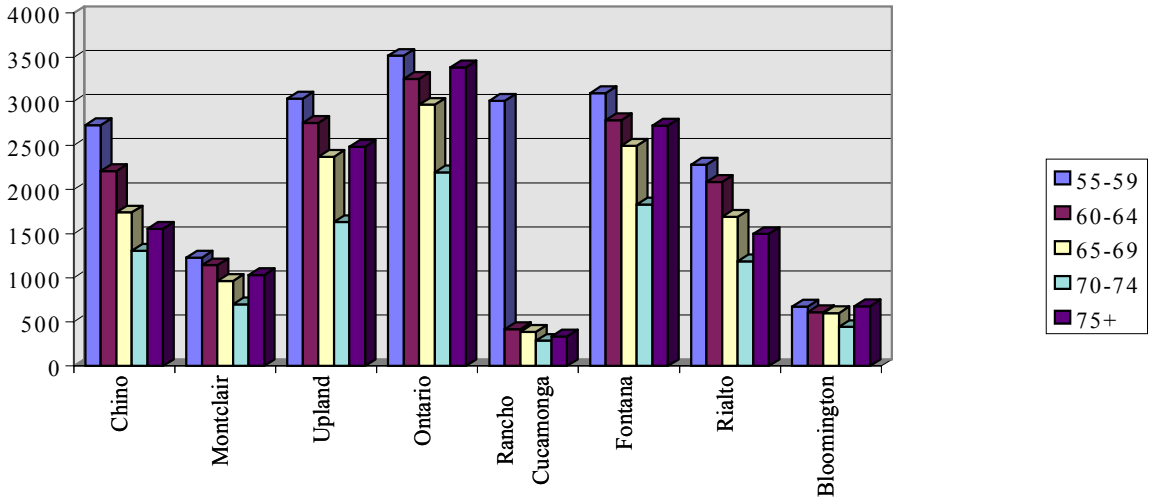


Chart 5-1990 Census STF-1 Age Cohorts by Tracts

Excluding the 55-59 age group, the 75+ population is the largest growing population in the West Valley Region. Similar to the East Valley metropolitan areas the 75+ population moved into the area many years ago when property was less expensive and today, many of these individuals are experiencing the same urban problems. They are in declining neighborhoods and unable to relocate due to fixed incomes. This is particularly true of Ontario. Upland has the largest number of seniors as a proportion of the general population with 25% or 1 out of every 4 people in Upland is over the age of 60.

The largest growth rate of the senior population has been experience by the Victor Valley Region. From 1980 to 1990, this region experiences 124% growth rate of its senior population. Trends for the 2000 census predict that this area's growth should remain steady as more older workers purchase homes in the communities that are more home for the buck than can be purchased in the Los Angeles and the surrounding metropolitan areas.

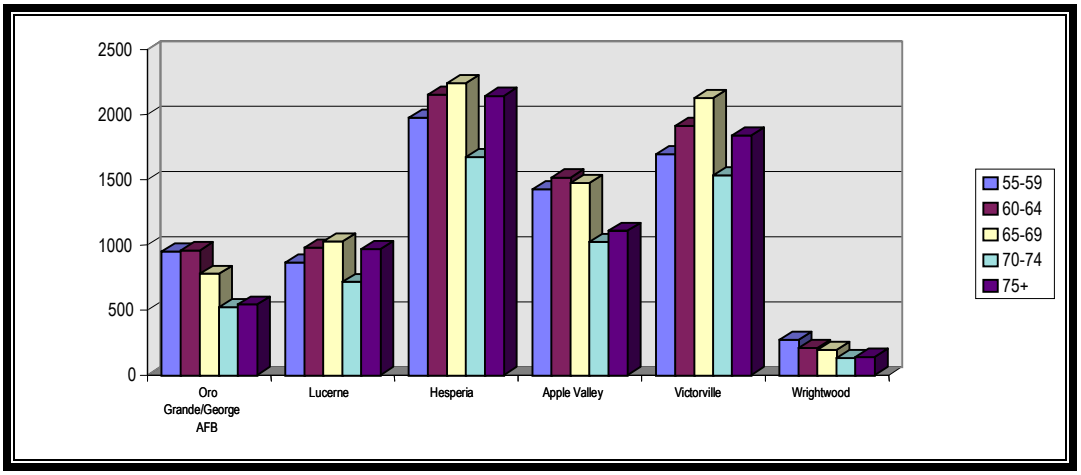
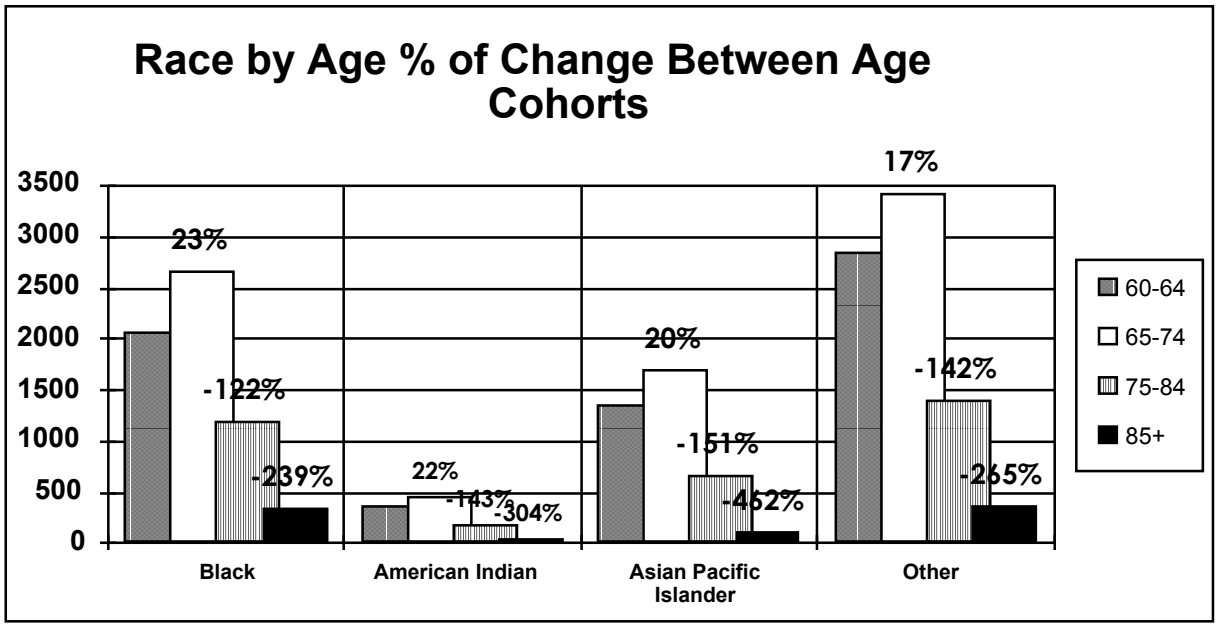


Chart 6-1990 Census STF-1 Age Cohorts by Tracts

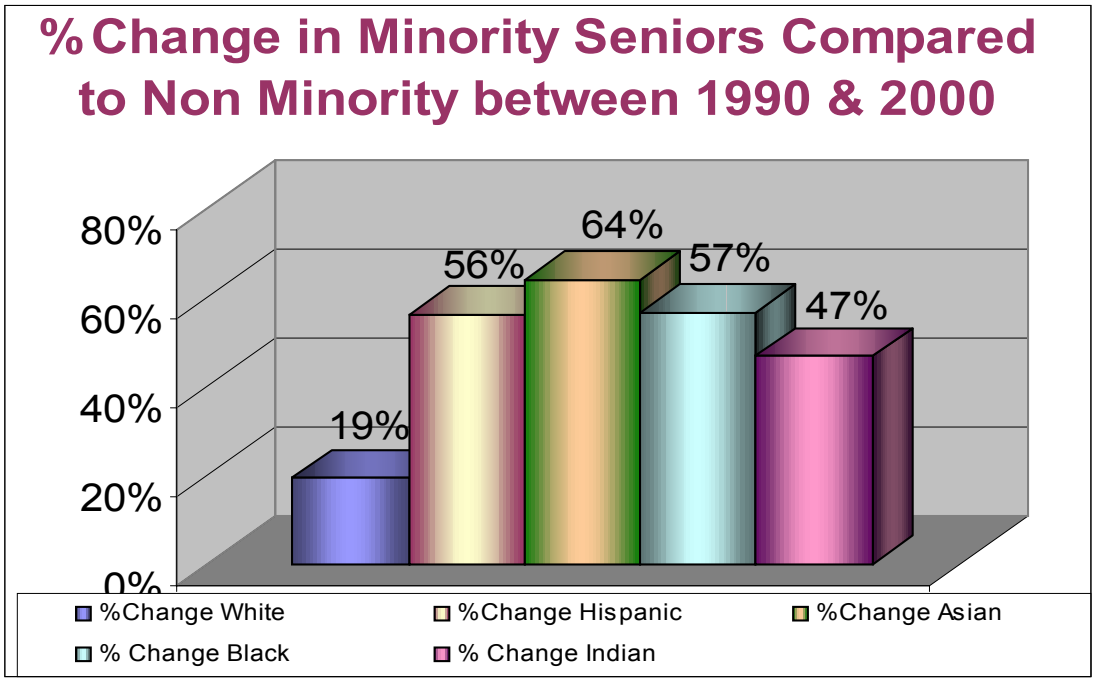
For example, the largest rate of growth was experienced by the 65-69 age bracket, which grew 145.98% and was centered on the cities of Hesperia, Victorville and Lucerne Valley. Even before the census figures were available, increasing demands for service in this region predicted substantial growth.

As stated by Bureau of the Census in a recent Current Population Reports, "In the coming decades, the elderly population will be much more racially and ethnically diverse than in the 1990's. Of the 80.1 million elderly projected in the middle series for 2050, 8.4 million would be Black; 6.7 million would be races other than White or Black; and 12.5 million would be Hispanic (who may be of any race). These totals reflect the Census Bureau's middle series projection assumptions. The observed totals will vary to the extent actual levels of international migration and survivorship, by race and Hispanic origin, depart from the projection assumptions. If the chance of survival improves more rapidly for each group than in the middle series assumption, the numbers shown would be even higher." For the first time ever, the 2000 census may demonstrate that the minority elderly collectively could be approaching the number of non-minority elderly.

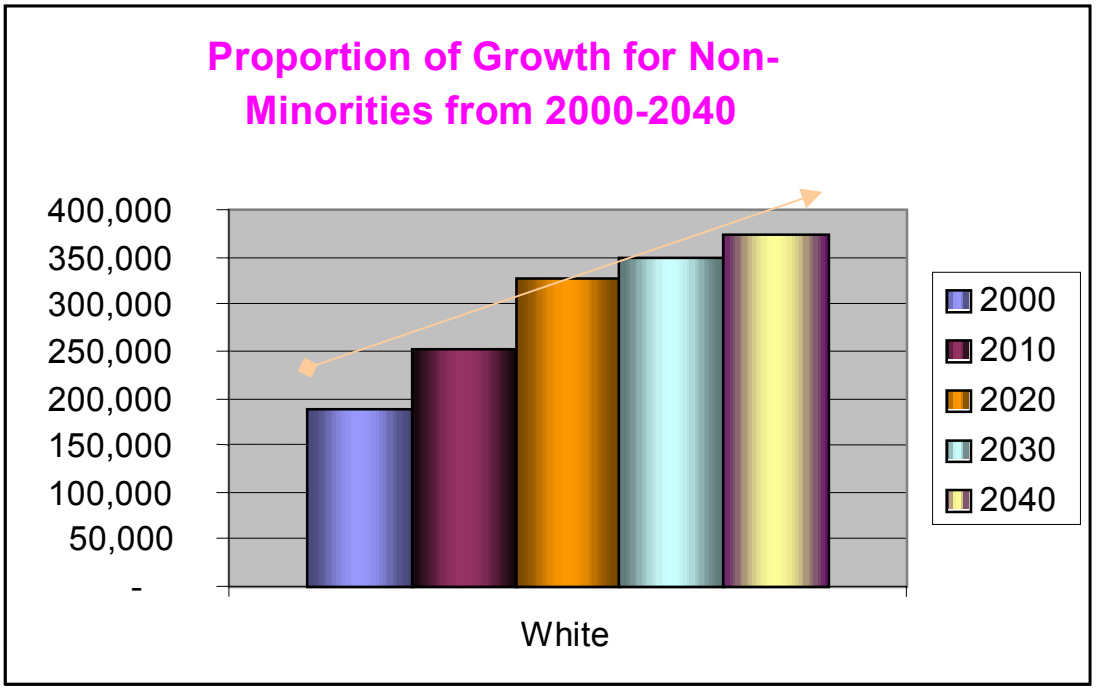
Compared to the overall senior population, which grew 36%, minority seniors have experienced the largest growth rates. The Black elderly went from 3,261 in 1980, to 6,319 in 1990, or grew 94%; American Indian seniors went from 762 in 1980, to 1,081 in 1990, or grew 42%; and the largest increase was experienced by the Asian Pacific Islander group who went from 859 in 1980, to 3,896 in 1990, or grew 354%.



The bar chart displays the percent of change between age cohorts. The Black elderly have the largest percent of increase, 23%, between the ages of 60-64 and 65-74, with the American Indian second at 22%, the Asian Pacific Islander at 20% and the category Other at 17%. The greatest decrease from one age group to another is experiences by the Asian Pacific Islanders with a decrease of -462% from the age group of 75-84 to 85+.



As the chart indicates, projected growth for minority elderly is on the increase with Hispanic elderly topping the chart at 64%, while the non-minority elderly are expected to grow at a much slower rate of only 19%.



The bar chart on the prior page points to the increasing longevity of the minority population as a whole, and is substantiated by two studies conducted by *AARP,* one of which was conducted in 1987 with an update to the information prepared in 1995. This study pointed out that minorities are living longer than they did 20 years ago,

primarily because of better nutrition and health practices; but conversely the study also points out that this does not always translate to an increase in the quality of life which may not have changed.

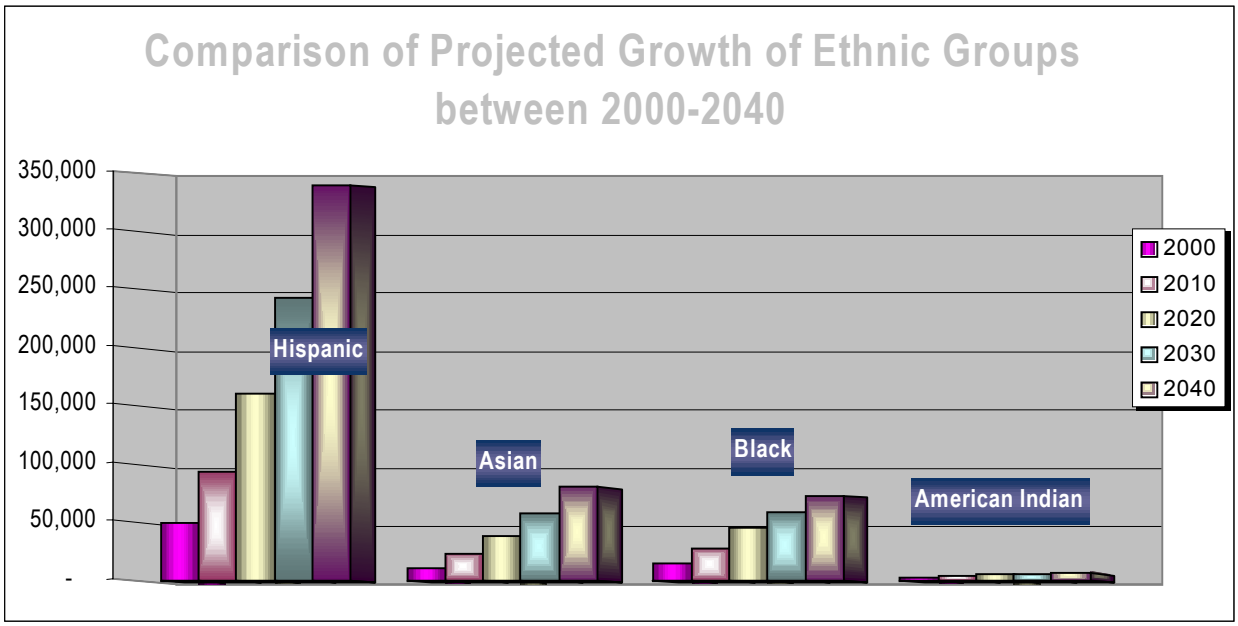


Chart 10-P-93 Report-Department of Finance- Minority Status Projections for FY 2000 through 2040

It is predicted that the minority elderly population will continue to grow through 2040. While persons of races other than White constituted 11% elderly persons in 1990, that will change significantly by 2040 when the proportion will increase dramatically. Over this period, the number of elderly Blacks could increase from 4% to 11% or almost triple their current ratio and Asian Pacific Islanders could increase from 2% to 12% with American Indians remaining at 1% of the total elderly population. By 2040 it is possible that the minority elderly population could reach 43% of the senior population in San Bernardino County.

Time Period	Hispanic	Asian	Black	American Indian	Total Minority	White	Total 60+
1990	8,066	3,896	6,319	1,081	19,362	151,070	170,432
2000	18,510	10,875	14,650	2,040	46,075	187,522	233,597
2010	35,161	22,981	26,825	3,336	88,303	251,305	339,608
2020	60,756	37,340	45,230	4,555	147,881	326,921	474,802
2030	91,990	56,992	58,359	5,382	212,723	348,411	561,134
2040	128,817	80,081	72,932	6,035	287,865	374,031	661,896

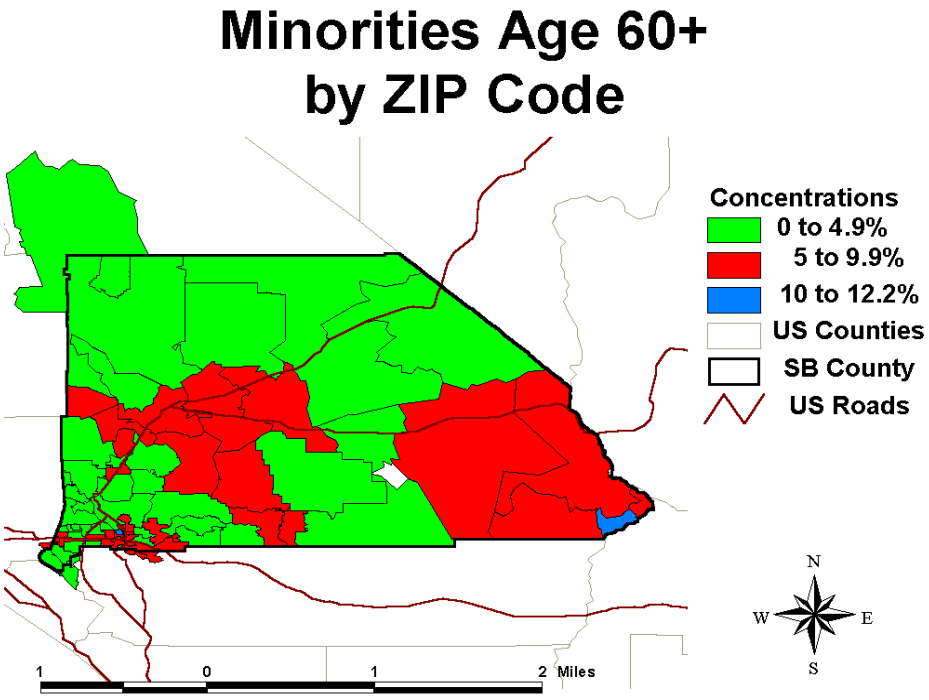
Table 1- Elderly minority population projected prepared from Department of Finance population projections

Time Period	Hispanic	Asian	Black	American Indian	Total Minority	White
1990	5%	2%	4%	1%	11%	89%
2040	19%	12%	11%	1%	43%	57%

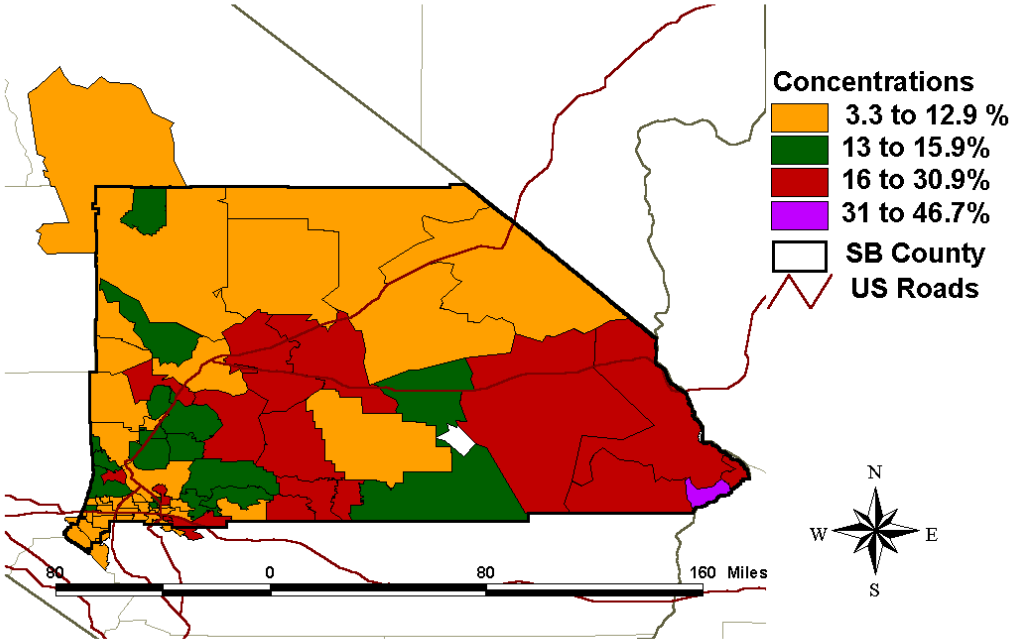
Table 2- Elderly minority population projected prepared from Department of Finance population projections

Implications for social policy change are great. The need for services that are culturally acceptable, with program information translated into languages other than English is of growing concern for many policy analysts. Particularly with the influx of older persons from Vietnam, Cambodia, Korea, and to a lesser extent China, the need for such services as nutrition, personal care, in-home supportive care etc. are growing as the younger individuals from these cultures who would have been the traditional care-takers of the elderly family members are assimilated into the "American Culture". A culture, which has been depicted as compartmentalized, prepackaged and fast frozen.

Projections for 2001 are displayed in the graphs on the following page. The first graph depicts the concentrations of 60+ for all the zip codes broken down by percentage of seniors represented compared to the total population starting with 3-12.9% and ending with concentrations of 31-46.7%. The second graph illustrates the projected minority senior growth by percentages starting from 0-4.9% and ending with 10-12.2%.



Concentrations of People Aged 60+ by ZIP Code



Preliminary findings from the census indicate that we can expect substantial increases to occur in the number of children living in households maintained by grandparents. This increase is attributed to drug use among parents, teen pregnancy, mental and physical illness of the parents, AIDS, crime, child abuse, neglect and incarceration of parents. Policy implications of the growing number of grandchildren being cared for by their grandparents encompass a broad range of issues. For the younger senior citizen, raising their grandchild will require that they delay retirement in order to pay for the additional cost of raising the child. This will also impact the number of older individuals who are available to volunteer their time and efforts at the numerous service sites operated by DAAS and it's provider network.

Current social structures have not kept pace with the increased numbers, strengths, and capacities of older persons. One suggested future direction of change is toward "age integration" where opportunities for work, education, and leisure are options for persons of all ages, throughout their lives. Emerging evidence in this direction appears as colleges open up to older and nontraditional students, as companies retrain older adults, as opportunities for older volunteers grow, and as the number of elderly acting as caregivers rather than care receivers increases.[3] Questions about the elderly of the future abound. While we know there will be many more elderly, projections vary in predicting how many more.[4]

In the County of San Bernardino, who are those most in need of services? They are the frail, minority, and poor elderly. These elderly are not nearly as visible as the hale, vocal, middle-income elderly that we see so often at nutrition sites and commission meetings. Often these elderly with special needs are tucked away in rural poverty pockets or isolated crime ridden urban neighborhoods, where they know little of service. National statistics for this group, which San Bernardino County also mirrors, is as follows:

[3] *Matilda White Riley, "Aging and Society: Past, Present, and Future," The Gerontologist, Vol. 34, No. 4, August 1994, pp. 436-446.*
[4] *Burton H. Singer and Kenneth G. Manton, "How Many Elderly in the Next Generation?," Focus, Vol. 15, No. 2, Summer and Fall 1993, University of Wisconsin-Madison, pp. 1-11*

- The poorest elderly are minorities, women, and the "oldest old" (85 years and older), and persons who live alone. In San Bernardino County, 72% of the elderly over 65 live at or below the poverty level.

- The poverty rate among black elderly (33.2 percent) was more than triple and among Hispanic elderly (22.4) more than double the poverty rate of white elderly, which was at (10 percent). In San Bernardino County, 2,682 minorities are at 100% of the poverty level. The frequency of poverty among the minority elderly is 18% for the Black elderly, 17% for the American Indian elderly, 11% for the Asian Pacific Islander elderly and 12% for all other minorities, compared to 7% for Caucasian elderly.

- The median income of elderly women was $7,655, or 58% of the income of elderly men, which was at $13,107. The oldest women are poorest. More than one in five women, 85 years and older lived in poverty, which is a trend that is growing.

- Increasing numbers of elderly women live longer – older men tend to remain married while women become widows or divorced. Twenty-three percent of older women living alone were below the poverty level, and 60.6 % of the Black women living alone were below the poverty. In San Bernardino County, based on the Needs Assessment, 62% were female, and of that percentage, 83% were at poverty.

- Eighty percent of those caring for frail older persons, either as family members or friends and neighbors, were women.

- Table A1-28 identifies by census tract the total 60+ population, the minority population, the 60+ population by age cohorts, and the 60+ low-income population. Four thousand two hundred and sixty-five minority elderly are at 125% of the poverty level, which constitutes 22% of the total minority elderly population, compared to 20,070 Caucasian elderly who constitutes 13% of the total Caucasian elderly who are low income. Poverty varies among the ethnic categories, for example, 26% of the Black elderly, 27% of the American Indian elderly, 18% of the Asian elderly, and 20% of all others are at 125% of the poverty level. *(Table 48. California Population Age 60 over with income at or below 125% of poverty level by race and Hispanic origin: for State, Planning and Service Areas PSAs and Counties)* 22% of persons 60 and over live alone and 26% of persons 65 and over live alone. Seven percent of the County elderly are rural.

- Persons suffering from Alzheimer's disease or related disorders are estimated at 12% of the total 65+ population. This is based on updated estimates prepared by DAAS using synthetic estimation. In using synthetic estimation, an assumption is made that the rates of a particular disease are similar in both the population studied and the population to which rates are applied. The percentages and preliminary estimates are contained in a study prepared by the California Department of Aging, dated July 1991.

This snapshot of the minority and poor elderly which illustrates the dimensions of a sub-population whose problems are masked by those who seem better off than ever before. The question DAAS faces, now and into the coming decades, is how to reach these at risk older persons and address their concerns.

Description of the Department of Aging and Adult Services

Newly formed in April 1992, DAAS enters its 9th year of operations. The value of this merger has many facets. Some of the most compelling is:

- Heightened coordination between aging and adult programs and staff.
- Greater flexibility in resource allocation.
- Enhanced program planning and policy development.

DAAS established three Regional Offices to serve the Desert, East Valley, and West Valley portions of the County. The Regional Offices have the responsibility for:

- Providing services to both dependent adults as well as seniors.
- Overseeing the day-to-day operations of all district offices within the region to assure that consistent, high quality service are provided to the people they serve.
- Operating the In-Home Supportive Services Program and the Adult Protective Services Program, and coordinating with Aging Programs.

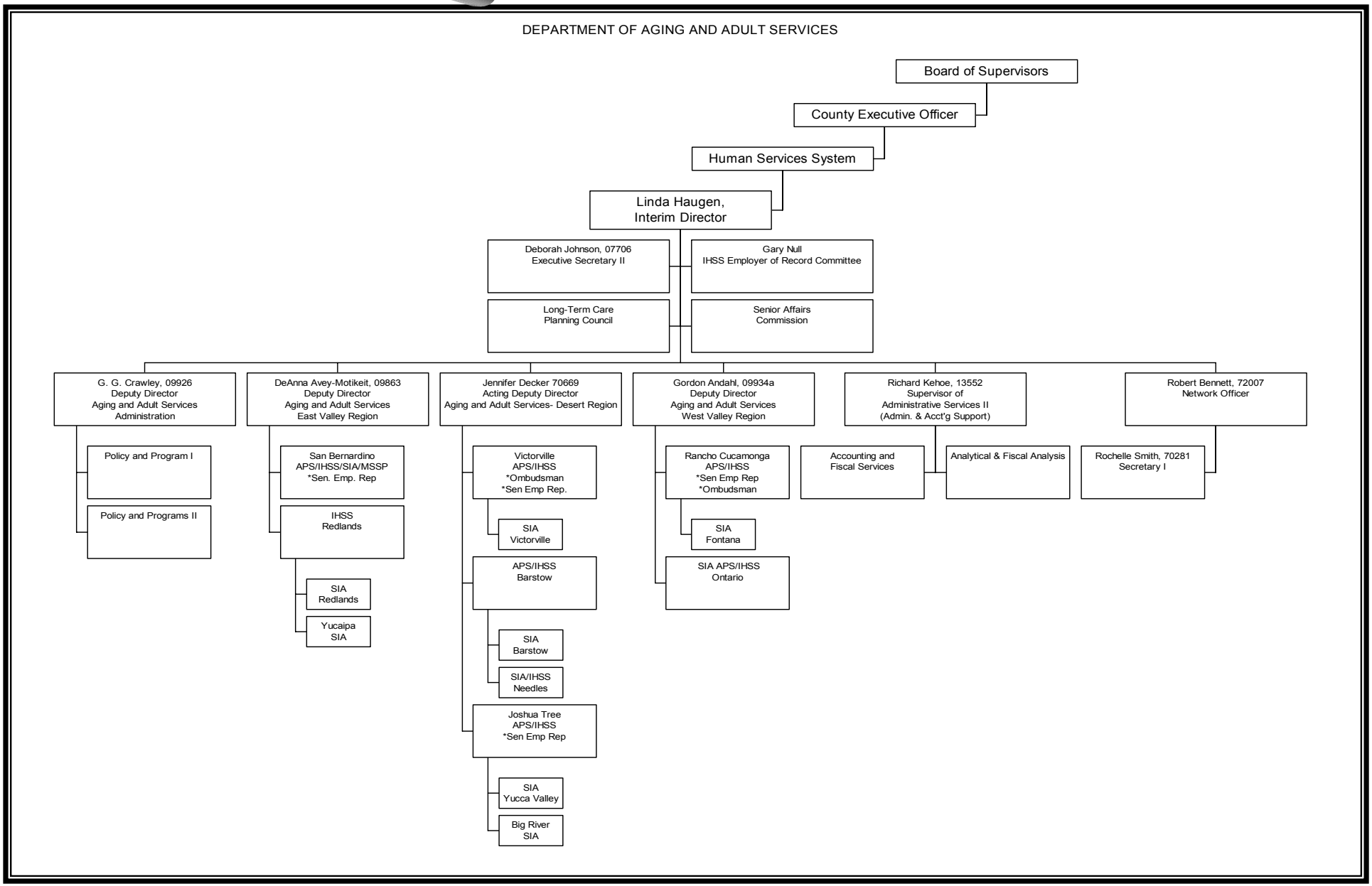
The regional offices are for the most part aligned to the existing planning regions and serve the elderly population in the following manner:

♦ The East Valley Regional Office will serve the East Valley and Mountains Regions.
♦ The West Valley Regional Office will serve those communities that comprise the present West Valley.
♦ The Desert Regional Office will serve the Victor Valley, Morongo Basin, North Desert and Colorado River regions.

The Administrative Section provides program development and coordination throughout the County. Some of the activities are:

- Developing and administering contracts
- Monitoring both Aging and Adult programs
- Developing and maintaining Management Information Systems
- Conducting Needs Assessments, Public Hearings and Community Forums
- Preparing, evaluating and updating the Area Plan
- Developing policies and procedures
- Drafting proposed legislation and analyzing potential impacts for proposed legislation
- Operating both the Senior Employment Program and the Long Term Care Ombudsman Program
- Working with special committees, councils etc.
- Coordinating with the Regional Councils on Aging and Adult Services within their region.
- Staffing the Senior Affairs Commission meetings and activities.
- Working with senior groups to form coalitions and networks to serve both the seniors and adults in their region.
- Developing new programs.
- Refining existing programs.

Organization Chart



Any Integrated Project should incorporate the values of choice, quality, independence, aging in place, in the least restrictive environment.

In 1996 DAAS applied to be one of two Integrated Long Term Care Pilot Projects in California. DAAS was successful and the State Department of Health in 1997 notified DAAS that we had been selected as an Integrated Long Term Care Pilot Project. In conjunction with the County Medical Center, and staff from Human Services System meetings were conducted to determine the best course of action to implement the system. The first item of business was to develop an administrative plan that would further define the program components with the anticipated date of initial implementation scheduled to be June of 1998.

By 1999, changes in the County of San Bernardino precluded further efforts for a front-end development of a LTC system. In 2000, the County of San Bernardino underwent a substantial and significant reorganization. Human Services System (HSS) was reorganized to include under it's umbrella Behavioral Health and Public Health as well as the Department of Aging and Adult Services, Department of Children's Services Community Services Department, Transitional Assistance Department, Children's Network, Veteran Affairs, Performance & Education Resource Center, Preschool Services Department, Information Technology and Support Division and Veterans Affairs. This reorganization was established to facilitate and systematize the delivery of human services to citizens who access many of the programs offered through the departments within Human Services System.

As a first step towards the establishment of a integrated human services system, the departments within HSS, along with representatives from the Probation Department, Arrowhead Regional Medical Center and the Public Guardian began participating in a planning process to review our existing services and explore potential opportunities for collaboration. Teams were formed to investigate:

- Communication & Marketing,
- Data Gathering—Programs & Services
- Data Gathering—Existing Resources
- Research—Models
- Funding Streams
- Legal Matters-Sharing Client Information
- Internal Public Agency Stakeholder Interests
- Client Stakeholder Interests
- Community Based Organization (CBO) Stakeholders Interests

From October 1999 through May 2000, Teams met and conducted a variety of data gathering, and research aimed at gathering a state of the arts on integration efforts conducted throughout the United States. The Research component identified 70 counties who appeared to have successful models. In no case were any one of the models completely integrated but the successful ones rather combined integration with collaboration and partnerships. The research identified three common elements that can lead to success or failure. They were:

- Input from the community and clients were essential in making delivery of service successful. Successful projects were community-driven and sought to know what the community was asking for rather than assuming to know what the recipients want.

- Turf issues of confidentiality were overcome through client release forms and interagency agreements.

- Successful integration projects were achieved through technology and emphasized the importance of establishing a master client index with electronic connectivity.

DAAS staff continues to work with the Integration team to develop a single point of entry or The Portal a “Door to all doors” type of organizational structure. Over the next couple of years DAAS plans to unfurl it’s own Central Intake process by expanding it to other Regional Offices so that clients can enter into the system from any location within the County of San Bernardino. This endeavor, along with the HSS Integration project, is anticipated to take up to five years to complete and, when done, will enable all the HSS departments to freely access and communicate on behalf of our clients.

DAAS continues to provide services that focus on aging in place and adapting services to the individual as the person’s needs change rather than having to move individuals when this occurs. This focus allows individuals to have maximum control over his/her lifestyle by having access to needed services without the disruption of moving to a new care center and incorporates the values of choice, quality, and independence which is an integral part of the values of the department. The services and staff activities DAAS commands either directly, through contracts or through collaboration are:

Intake: A unified intake form, interview and procedure has been developed to allow for "one stop" access to services. The purpose of the intake process is to determine the need for a comprehensive assessment for home and community based services. Intake services are provided at one location in Redlands and are scheduled to be expanded during the next two years.

Assessment: Includes in-depth assessment/analysis of recipient/applicant’s situation and circumstances, including presenting and underlying problems, coping skills, patterns, as well as health, environmental, and social issues. The comprehensive assessment focuses on the person and their ability to function and consists of a social assessment, psychological assessment, functional assessment, health history, medication review, environmental assessment, and if appropriate a complete physical exam, comprehensive lab evaluation, and/or cognitive testing as a basis for determining an appropriate service plan to maximize independence. DAAS social worker/nurse teams in conjunction with other County agencies forming a multi disciplinary team as appropriate (i.e. Behavior Health, Public Guardian, Department of Geriatric Medicine) will complete the assessment.

Medi-Cal Determination: A determination of eligibility for Medi-Cal is completed as a part of the assessment in order to assist the recipient/applicant and their family in planning for long term care services.

Information and Assistance: Applicant/recipient is provided with necessary information concerning other agencies, programs, services, resources which are specific to applicant/recipients needs and/or problems and is referred to other agencies, programs, services, and resources. Follow-up is provided routinely to ensure that other entities respond to applicant/recipients situation.

When the case plan calls for ongoing care services, the DAAS case manager will provide the information and referral services. When the case plan does not identify the need for ongoing care services the information and referral, including the follow up will be provided by DAAS Information and Assistance staff. Currently information and assistance is provided in nine DAAS offices located throughout the County of San Bernardino and accessible through an 800 toll free telephone number.

Advocacy and Coordination: Active and appropriately assertive representation is provided in representing the applicant/recipient’s needs to other agencies, programs, services, resources and significant others in obtaining necessary goods and services. Assistance in utilizing formal appeal processes, mediation, consultation and coordination of services is provided.

Volunteer Recruitment and Training: Recruitment, screening, registration and training of volunteers is provided by DAAS to serve consumers of our services. Volunteers are utilized to provide direct services to consumers and for support services to DAAS staff. Trained volunteers are utilized to provide Ombudsman Services, health insurance counseling and advocacy, transportation, advocacy, visitation, telephone

safety checks and reassurance, health promotion, risk prevention, and to meet other identified needs as appropriate. Volunteers are not used in lieu of professional staff but supplement the services provided by staff.

Health Insurance Counseling and Advocacy: DAAS contracts with HICAP to provide confidential assistance, counseling and information on health insurance, Medicare, Medi-Cal, Health Maintenance Organizations and long term care and limited legal assistance by trained volunteers. Volunteers assist with necessary paperwork, writing letters, phone calls and arranging for follow up action as appropriate. Services are provided through a formal agreement with HICAP. HICAP operates at fifteen sites throughout San Bernardino County.

Case Management: IHSS, MSSP and Linkages Services currently provides this type of comprehensive care planning. This is a process of coordinating and monitoring a wide range of medical and social services to meet the needs of frail older recipients and younger disabled adults. Case managers are responsible for insuring the standards of service delivery best needed to meet the needs of the recipients. DAAS staff is the designated case managers.

- **Case Planning**: Case Manager, in partnership with recipient, develops and carries out a case plan, which addresses problem areas/concerns/needs of recipient. The Case plan is specific and time oriented and describes activities to be carried out by Case Manager, recipient and others, time frames within which activities will occur and proposed date for follow up and reassessment. Case Manager provides both direct services as well as arrange for service delivery through others. The Case Manager provides counseling, evaluation, follow-up and supervision with respect to the case plan. Case Planning is done by the Case Manager who is DAAS staff. As appropriate, it may also be a collaborative effort on the part of the regional Multi-Disciplinary Team who staffs particularly serious cases.
- **Monitoring:** Activities necessary to assure quality of care and follow up for the recipient are provided by the Case Manager to determine that the services obtained were appropriate to the need, adequate to meet the need, of acceptable quality and provided in a timely manner.
- **Reassessment**: Activities necessary to examine the current condition of the recipient and to evaluate the effectiveness of the current service plan and to review the progress made toward achieving the objectives identified in the case plan.
- **Case Plan Modification:** A modified service plan is developed to meet the needs of the consumer as the consumer's situation or needs change. A modified service plan is developed as a result of each reassessment.
- **Closure:** DAAS Services are discontinued when the consumer's health and functioning improve to the degree that the consumer no longer needs the services, or when the consumer moves out of the County of San Bernardino, or upon the death of the consumer.

Adult Protective Services: Provided by DAAS Adult Protective Services (APS) staff. The frail elderly and dependent adults are very much at risk of abuse, neglect and/or exploitation at the hands of others. Applicants/recipients often experience self-endangerment related to pronounced difficulties in handling the affairs of daily living. The full range of activities necessary to carry out protective services involvement to applicants and recipients who are victims of abuse, neglect, and exploitation are provided including but not limited to investigation, assessment, treatment plan formulation, treatment plan activities and termination assessments. Comprehensive investigations include diagnostic issues as well as forensic issues and tangible needs. Adult Protective Services intervention is the least intrusive possible in eliminating/reducing risk factors. The developmental needs of the recipient's entire support system are addressed in a growth-oriented manner using family/group-centered interventions when possible.

Health Related Services: Services are provided to enable applicant/recipient to obtain preventive and remedial medical care, to locate appropriate medical care, to understand and accept the conditions and the treatment plan, to obtain medication, appliances and other assistive devices, to understand the illness and its treatment and to provide the necessary emotional support. Services are currently secured by DAAS Case Manager.

Preventive Health Care: Assistance is provided to consumers to improve or maintain their health and well being through medical screening including weighing and measuring at Department of Public Health clinic locations and senior centers throughout the County of San Bernardino. Consumers for whom possible medical problems are detected are routinely referred for ongoing medical care and health related services are provided to insure they receive the needed medical attention.

Discharge Planning: Services are provided to a recipient/applicant of MSSP/Linkages/IHSS soon after the individual is admitted to any given health care setting to facilitate continuity of recipient care, based on the case plan, and to maximize recipient's independence and choice. The Case Manager works with the hospital staff to ensure consideration is given to recipient's comfort and that quality care is provided in a compassionate and economical method. Discharge planning ensures that the post acute care provided continuity of the case plan prior to hospitalization and meets recipient and family preferences for outcomes and type of post acute care. It includes educating the recipient and family members about care options, the risks and benefits of each option, the attributes of each and the medical, health and social issues that need to be addressed depending on the option selected. It includes coordinating activities to arrange the transfer of appropriate information and ensuring that transportation is available for the recipient when discharge occurs. It includes follow-up to ensure needs are being met and to evaluate and improve the plan. Discharge planning is usually provided by hospital social service or discharge planning staff.

Home and Money Management Services: Services are provided to enable applicant/recipient to preserve and/or improve their skills in home management, personal care, nutrition and money management. Services include assistance in relating needs to landlords, obtaining repairs and maintenance on their home or apartment, money management, coping with the financial obligations of managing a home on fixed income. Service coordination is conducted by DAAS Case Manager. Referrals, as appropriate, will be made to Inland Mediation, Inland Legal Services, Community Services Home Repair, Steelworker's Home Repair Program, County Consumer Affairs, Consumer Credit Counseling, Salvation Army Sub Payee Program, Community Development Center, Agricultural Extension, and other community programs.

Personal Care Services: Assistance in personal care is provided through individual contracts between recipient and provider with DAAS staff monitoring to insure quality of care. Personal care services is an alternative to out-of-home care for aged, blind and individuals with disabilities who are unable to safely remain in their own homes without this assistance. Personal Care Services include bowel and bladder care, respiration, feeding, routine bed baths, dressing menstrual care, ambulating, moving in and out of bed, bathing, oral hygiene, grooming rubbing skin, reposition, and care and assistance with prosthesis. This program is administered by DAAS staff with actual service delivery provided through individual contracts between recipient and provider with DAAS staff monitoring to insure quality of services. DAAS continues to maintain a ready pool of screened individuals from which recipients who do not have an identified provider may select. The current pool of screened individuals interested in being a provider is in excess of 9,000 individuals.

Homemaker Services: Administered by DAAS staff. Provided through individual contracts between recipient and provider with DAAS staff monitoring to insure quality of services. Homemaker services include domestic service, preparation of meals, meal clean up, routine laundry, shopping for food and other shopping and errands, and heavy cleaning. DAAS continues to maintain a ready pool of screened providers from whom recipients who do not have an identified person to serve as a provider can select. The current pool is in excess of 9000 providers. DAAS will monitor the quality of the delivery of services and will be available to assist in the selection, hiring, firing, and resolving of problems with respect to the provider.

Caregiver Support Services: Services to support caregivers that emphasize the positive aspects of their relationship are provided including structured activities for couples, recipient and caregiver and stress reducing training and activities. Education about the form of illness and the choice of the kind of care most appropriate for their loved one will be provided to caregivers. Respite care is also provided through contracts for caregivers at adult day care, and/or adult day health care. A Web site has been developed for DAAS this last fiscal year and plans for

expanding it to include electronic support groups will be established to allow caregivers to obtain information as the condition changes. Services are also provided through an agreement with Inland Caregivers Association.

Hospice Services: Activities to enable the terminally ill consumer to remain in their own home and to die in the comfort and security of their home and family are provided upon the wishes of the consumer. Services are provided through agreements with local hospice programs and by supplementing the programs with other available home and community based services. Adaptive devices and support are provided to the consumer and his/her significant others to enable the wishes of the consumer to avail when at all possible. Medical equipment, supplies and home adaptation are provided as needed to meet the needs of the consumer in part through the Special Circumstances Program.

Emergency Response Services: Emergency Response units are provided for consumers who are in need of the units to enable them to remain safely in their own homes. Generally the units are provided for those consumers who live alone or who live with family who are employed and away from the home for extended periods of time. The units are provided through agreements with local service providers.

Home Health Care: DAAS has a number of small vendor agreements with nonprofit home health agencies throughout the County. DAAS currently has vendor agreements with approximately nine (9) home health agencies in the East and West Valleys. Home health agencies are also being recruited in the Desert communities and vender agreements developed to assist older citizens within these communities as well.

Nutritional Services: Consulting Health and Nutrition is a contract with DAAS that provides evaluation and nutritional counseling for older individuals. Home delivered meals are provided by the five contractors located throughout the County and the three nonprofit Meals on Wheels Programs. Congregate Nutrition services continue to be provided by the six congregate contractors.

Transportation: Services that enable recipients to gain access to community services and resources required by the case plan are provided. Family, neighbors, friends, and/or community agencies who can provide transportation at no charge are used whenever possible. Existing transportation systems are utilized as available. MedTrans is utilized for medical transportation. A community partnership currently exist between DAAS and MedTrans with MedTrans providing vehicles that are taken out of circulation for delivery of home delivered meals, information cards, and vials of life for recipients of DAAS services. DAAS will continue to work with Transportation and Flood Control, the Senior Citizens Foundation and other community agencies to expand the Transportation Reimbursement Escort Program (T.R.E.P.) to provide transportation services to those areas of the County currently unserved. DAAS has secured an agreement with the Dept. Of Transportation and Flood Control that as money for transportation becomes available they will increase the funding to DAAS to expand the geographical areas served by T.R.E.P.

Ombudsman: Provides confidential investigation and resolution services, unannounced visits to long term care facilities by trained, State-certified volunteers, community education about residents' rights and entitlements, and public information about long term care facilities in our County. The Ombudsman Program is mandated to receive, investigate and work to resolve problems and complaints on behalf of residents in nursing homes and residential care facilities.

Out-of-Home Care Services include providing recipient with placement options, assisting recipients and their loved ones to carefully choose a care option based on their own individual needs, life situations and financial status, providing background information on the facilities, providing counseling in adjusting to placement, assisting in contacting relatives and significant others, advocating with facility personnel and other significant health care providers and will be provided by DAAS staff. Monitoring and other services are provided by the DAAS Case Manager and by the Volunteer Ombudsman assigned to the facility.

Housing and Residential Services: Provides assistance in resolving disputes with landlords, in obtaining needed repairs to home or rental unit, in obtaining modifications to meet special needs of the consumer, in obtaining affordable and safe housing and in obtaining furnishings and household items to allow the consumer to adapt the physical environment to meet his/her special needs such as ramps, safety bars, a chair or bed that raises up to assist the individual to get up, a microwave oven and other items necessary to meet the needs of the consumer. Emergency shelter particularly for Adult Protective Services clients are provided for those individuals who are in immediate danger due to the environment or the actions or in-actions of others. This will be accomplished through voucher arrangements with local hotels/motels and through agreements with local residential care facilities and skilled nursing facilities to provide temporary emergency care appropriate to the needs of the consumer.

Adult Day Care: Services for those who have difficulty taking care of themselves at home but wish to maintain their independence are provided in a day setting in a friendly environment in which they may engage in social activities and recreation and receive a hot lunch as a part of the case plan. Services are provided through agreements with adult day care facilities including but not limited to Seville's Senior Center, Knolls West Day Care for Seniors, and Morongo Basin Adult Day Care.

Adult Day Health Care: An organized day program of therapeutic social, health, and recreational services to assist in restoring or maintaining, to the fullest extent, the individual's capacity for self care while under the direct supervision of professional staff is provided in accordance with a case plan. Service is not provided in increments of less than two hours. Additional services including, but not limited to, physical therapy, occupational therapy and/or speech therapy may be provided at the day care facility if it is a part of the recipients case plan. Services are provided through agreements with Adult Day Health Care facilities, including but not limited to, the Other Place, Yucaipa Adult Day Center, Highland Adult Day Health Center, Alzheimer's Day Care Satellite Program, Adult Day Services and Crossroads Adult Day health Care.

Home Delivered Meals: Meals are delivered to the home five days per week with special provisions made for weekends and holidays for consumers who are unable to leave their home. Voluntary and confidential donations are accepted for the service from consumers who are age 60 years or older as required by the Older American Act. Services are provided through expanded contracts with the five existing Senior Nutrition Contractors currently providing home delivered meals.

Medical Equipment and Appliances: Specialized Medical equipment, appliances and supplies which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live are provided. Items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable Medi-Cal equipment will also be available.

Out of Home Care Services: These services are provided to adult individuals whose condition is such that IHSS and other services are no longer sufficient to maintain the recipient's safety/well being in their own home or other independent living arrangements and are in need of placement. The goal is to restore the individual to independent living whenever possible and to enhance the quality of life for persons who must remain in placement. Out-of-Home Care Services includes, but are not limited to, the following arrangements:

- **Assisted Living:** Room and board in a private apartment with 24-hour supervision and protection will be provided. Services include organized activities, intermittent nursing services, management of medication, assistance with dressing and personal hygiene, behavioral management and a licensed nurse available as needed.
- **Board and Care:** Room and board is provided in a licensed residential facility with 24-hour supervision and protection. Services include room and board, management of medication, organized activities, assistance with dressing, bathing, and planned activities. There are 240 licensed residential care facilities for the elderly

with a total of 4,176 beds and 299 Community Care licensed facilities with a total of 9,354 beds in San Bernardino County.

- **Skilled Nursing Facilities:** Nursing and custodial care is provided on a 24 hour basis in hospital like facilities that provide a friendly and caring atmosphere, provide more than nursing care, that welcome input and suggestions for improving service and encourage innovation and in which staff are flexible enough to accommodate recipient's needs. Nursing facilities are most appropriate for individuals who need a more protective setting and who have medical and behavioral needs that cannot be met in other care settings. All residents will be screened before they enter a nursing facility to determine if a nursing facility is really the best place for that person and to help the individual and their families explore other options. Priority will be given to facilities that treat employees as valued assets, that provide training to employees in long term care, in which recipients, family members, and DAAS staff are encouraged to attend care planning sessions, and in which residents have choices in their daily lives such as wake up time, time of bath, bed time, etc. San Bernardino County has 59 licensed skilled nursing facilities with a total of 5,178 beds. The facilities run approximately 30 to 50 percent vacancy factor.

Additional services are provided in accordance with the case plan through Older American's Act Programs operated by DAAS, other County and community agencies, and the purchase of service process. Prior to initiating the purchase of service process DAAS will determine available services among governmental agencies and private firms and agencies.

Finally, during the next four years, DAAS expects to expand on its prior activities and initiate new activities, which will make significant strides to fully establish an Integrated Service system. DAAS plans to foster activities that lead to:

* New and expanding existed Inter-agency Agreements.
* Development an Aging and Adult Services Network
* Stronger ties with Health Care Providers, particularly physicians, to promote wellness and educate the elderly, particularly the minority elderly, regarding alternative solutions to institutional care.
* Development of an Integrated Intake Process which will serve as a benchmark for other counties within the state.
* Increased utilization of the Multi-Disciplinary Team located in all areas of the County to resolve chronic client problems.
* Develop Financial Assistance Support Teams FAST to mitigate financial abuse of older individuals and younger disabled adults.
* Encourage wider utilization of volunteers in all levels of the organization.

MISSION STATEMENT

Serving seniors and at risk individuals to maintain or improve choice, independence, quality of living, aging in place while living in the least restrictive environment.

Values

Treating customers as we would hope to be treated when faced with similar life-stage needs or issues is an integral DAAS value for the deliver of services. It forms the foundation for the Department's mission of providing quality services to the County's well and at risk elder/dependent adult populations. This value establishes the standard that all recipients of DAAS services are to be treated with dignity, empathy and respect for their self-worth. DAAS is governed by the following standard: "Would we refer our parents or disabled family members to our own programs?"

DAAS also administers the In-Home Supportive Services and Adult Protective Services to the County's at risk elderly and dependent adult populations. DAAS is committed to safeguarding the rights of vulnerable adults, supporting caregivers and promoting prevention. In support of this endeavor DAAS is committed to:

- Compassionate delivery of services.
- Commitment to consumer-focused/client centered delivery of services.
- Competent staff working effectively to serve consumers.
- Provision of quality services through staff, management and consumers working in concert to identify necessary changes for improving service delivery systems.
- Utilization of professionally and successfully proven knowledge and skills in the delivery of services.
- Consumer participation in program planning.
- Preservation of independent life-styles.
- Flexibility to respond to the needs of individuals, their families and caregivers.
- Consumer choice and self-determination.
- Consumers involved in designing and monitoring the system.
- Equally accessible to diverse populations.
- Consistent policy with local control and implementation.
- Provide preventative services, home and community based support and institutional care.
- Cost containment and fiscal incentives consistent with the delivery of appropriate services at the appropriate level.

DAAS is also the County department responsible for planning, coordinating and funding programs for all functionally impaired adults and for educating the public on these issues.

Planning Process

Planning for the four-year plan began in November 1999, with the first meeting of the Policy Committee to determine future goals/objectives and actions. During January, February, March and April 2000, 39 Public Hearings were conducted to collect data for identifying the needs of the County of San Bernardino's older citizens and adults with disabilities.

Timeline for the planning process was as follows:

November 1999	First meeting of the policy committee is convened.
February – April 2000	Needs Assessment was conducted at 39 locations.
May 2000	Preliminary Public Policy Paper for the Desert Region is prepared and submitted to the Supervisor of the First District.
June 2000	Set-up Access database and pilot test assessment forms.
September-Dec 2000	Key enter the Needs Assessment forms
January 2001	Analyze the Needs Assessment data and write up findings.
February 2001	Write the narrative portion of the Area Plan including demographic profile, organizational overview, etc.
February 26, 2001	Formulate Goals and Objectives for the Area Plan with Commissioners and Management Staff.
February 27, 2001	Prepare final draft s and Executive Summary.
March 15, 2001	Management reviews final draft & make copies for Public Hearings
March 22-April 5, 2001	Conduct Public Hearings.
April 6, 2001	Amend Plan to include Public Hearing comments.
March 11, 2001	Submit Plan to County Counsel and Senior Affairs Commission for Review.
April 12, 2001	Send agenda item to BFD Secretary.
April 23,2001	Building and Finance Analyst finalizes the review.
April 24, 2001	Hard copies of the plan and agenda item at the CAO office.
April 30, 2001	Approved by the Board of Supervisors
May 1, 2001	Original and copies sent the California Department on Aging

The Policy Committee was newly formed in November 1999 and was intended to provide structure and guidance for the Senior Affairs Commissions committees. The committees meet on a regular basis and discuss the major program and policy areas of:

- Regional Councils on Aging and Disabled Adults
- Ombudsman Services
- Intergenerational
- Transportation

- Access
- Legislation
- Housing
- Health
- Nutrition
- Senior/Adult Abuse Prevention

These meetings serve as focus groups for the committees and staff is assigned to assist them in developing clear cut goals and objectives that will enable the committees to move the Department of Aging and Adults Services along a path towards greater integration of services for the elderly within the County.

For example, the Integration Committee will take part in Hearts and Minds: Diversity in Action sponsored by Cal State University-San Bernardino on May 11, 2001 as a panel of presenters in one of the workshops. This fourth annual event is gaining a reputation for innovative approaches to social policy. The Integration Committee is comprised of persons from all walks of life representing all age levels from high school students to persons 85+. It is this type of representation that will enable this committee to be on the leading edge in assisting DAAS in the 21st Century. The Transportation committee is composed of representatives from Para-Transit, Omnitrans, the Senior Affairs Commission, and staff of DAAS. The Housing Committee will be composed of representatives from HUD, Mobile Home Association, Staff and other interested organizations and persons. The Health Committee is comprised of individuals from the Department of Health, the Senior Affairs Commission, and interested older persons.

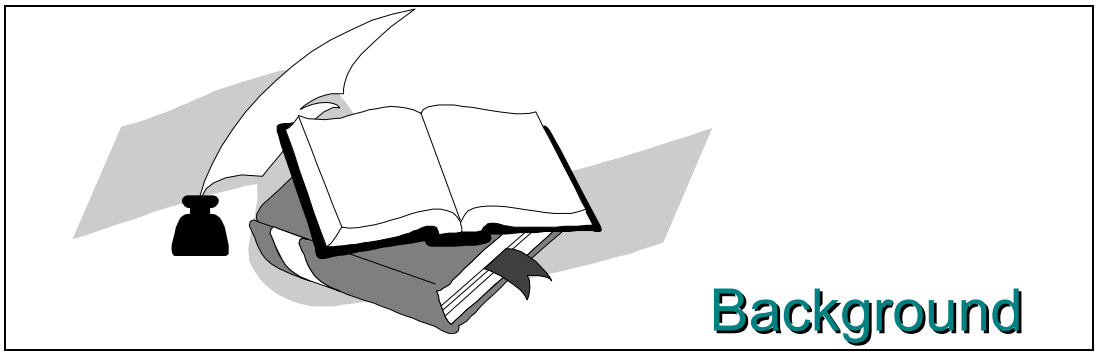
Each committee is structured to garner broad-based support from other agencies, organization, and the community in general.

Need Assessment Process

The San Bernardino County Department of Aging and Adult Services in its capacity as the Area Agency on Aging, has as its primary responsibility the assessing, planning and provision of services for the County's senior citizens. In part, DAAS fulfills its mandate by:

- Determining the need for service by soliciting the views and active participation of older adults in the planning process.
- Establishing meaningful goals and measurable program objectives to meet those needs.
- Contracting with appropriate providers to fulfill the needed services.
- Providing Direct Services
- Monitoring and tracking contractor performance.
- Coordinating with other private and public entities and acting as a catalyst for change.
- Providing accurate and timely reports to various funding sources.

The needs assessment is the first step in the planning process. It sets the direction and focus of the Area Plan, and enables the department to mobilize its resources to develop programs and services to address those needs.



Planning for the Needs Assessment began in October, 1999, with a review of three instruments, one of which was developed by DAAS for the prior planning process, and the second which was designed and used for the White House Conference on Aging and the Need Assessment designed by a task force of the California Department of Aging served as the third source document from which to pull key questions**.** The documents were invaluable sources from which to pull key questions that served as the basis for the final version of the Needs Assessment Form. (See Part Six)

Questions regarding Individual Activities of Daily Living were limited to a second tier Needs Assessment and provided a small sample of responses from individuals living in Residential Care Facilities. These questionnaires were administered by trained volunteers of the Ombudsman staff and are intended to measure each individuals ability to perform the activities of daily living and to serve as an index using Synthetic Estimation for applying this information to the County's overall elderly population to determine functional levels particularly for individuals 75 and over.

Between the first and second tier assessment, 1,212 individuals filled out the Needs Assessment. Verbal testimony was received from over a 1,000 senior and disabled adults. A wide range of clients, from those individuals who were completely homebound receiving home delivered meals and other in-home services, to those fully capable of attending social activities, were surveyed during the months of January through March of 2000. The methods used to analyze the assessments, the subsequent findings and the recommendations made as a result of this activity are organized in this section as follows:

- Lists the Methodology
- Compares the client profile characteristics with the 1990 census.
- Summarizes the findings.

Methodology

Prior to finishing the public hearings a database was designed using Microsoft Access. Once the assessment forms were returned, they were numbered then batched and keyed into the computer. This process required two months with one individual working an average of two hours per day. Not all of the assessment forms were completed, some were missing client profile questions, and others only listed their top service needs. However, information from partially completed forms was entered into the computer and the blank sections were identified as "No Response". The profile is displayed as an attachment in Part Six. Cross tabulation of the results and gross data scores along with comments by the participants are also contained in the same section.

Client Characteristics Compared to the Census

Since the 2000 census was not available at the time of this writing the 1990 census was used as a baseline to compare selected profile characteristics and to gauge how effective both DAAS and the providers have been in reaching the isolated, aged, minority low income and the senior population with disabilities.

Of those assessed, 3% lived alone, compared to 32.5% in the 1990 census. Of the clients who filled out the assessment form, 43% were 75 or older. By comparison, 43.21% were 75 or older in the 1990 census. Minorities were represented in excess of their proportion within the senior population. Of those completing the form, 5% were Black, 3% were American Indian, 1 % were Asian Pacific Islander and 7% were Hispanic compared to their representation in the 1990 census of 2.5% Black .07% American Indian and 7.8% Hispanic. To continue focusing our effort to reach this population, targeting goals and related objectives have been established and are included in the PSA Plan in Part Two. Low-income seniors represented 22% of all assessed, by comparison, in the 1990 census, low income represented 8.59%.

Analysis of the client profile indicates that the Department of Aging and Adult Services is indeed reaching and providing service to those most in need of service. For an overview of the needs assessment documentation see Part Six which contains a copy of the Survey Questionnaire, the Client Profile and a Summary of Needs Assessment broken down by Supervisorial District and further broken down by selected Profile Characteristics plus participant comments and types of disabilities.

Findings

The San Bernardino County Department of Aging and Adult Services held public hearings for seniors and younger individuals with disabilities. Two thousand two hundred and twelve individuals attended the community forums held during the months of January through April throughout the County of San Bernardino. The Communities, which hosted the public hearings and the order in which they occurred are as follows:

1	Adelanto	January 13-00	9:00 a.m.	Adelanto Community Center
2	Hesperia	January 13-00	1:00 p.m.	Hesperia Public Health Center
3	29 Palms	January 14-00	9:00 a.m.	29 Palms Community Center
4	Yucca Valley	January 14-00	1:00 p.m.	Yucca Valley Community Center
5	Pinon Hills	January 18-00	9:00 a.m.	Pinion Hill Community Center
6	Victorville	January 19-00	9:00 a.m.	DAAS Conference Room
7	Apple Valley	January 19-00	1:00 p.m.	Council Chambers
8	Red Mountain	January 20-00	10:00 a.m.	Red Mountain Senior Center
9	Trona	January 20-00	1:00 p.m.	Trona Senior Center
10	Newberry Springs	January 21-00	10:00 a.m.	Senior Center
11	Barstow	January 21-00	1:00 p.m.	Mojave Valley Senior Center
12	Baker	February 03-00	10:00 a.m.	Senior Center
13	Phelan	February 11-00	9:30 a.m.	Phelan Community Center
14	Lucerne Valley	February 16-00	1:00 p.m.	Senior Center
15	Big River	February 18-00	9:30 a.m.	Fire Station
16	Needles	February 18-00	3:00 p.m.	Council Chambers
17	Yucaipa	February 23-00	10:00 a.m.	Yucaipa Senior Center
18	Highland	February 23-00	1:30 p.m.	Senior Center
19	Grand Terrace	February 24-00	9:00 a.m.	Community Room
20	Redlands	March 1-00	1:00 p.m.	Public Library
21	Colton	March 1-00	9:30 a.m.	Colton Community Center
22	Loma Linda	March 2-00	9:30 a.m.	Council Chambers
23	Rialto	March 2-00	1:00 p.m.	Community Center
24	Rialto	March 8-00	10:00 a.m.	Senior Center Mobile Home Park
25	San Bernardino	March 8-00	1:00 p.m.	Villa Senior Library

26	Fontana	March 09-00	9:30 a.m.	Council Chambers
27	Rancho Cucamonga	March 10-00	10:00 a.m.	Rancho Cucamonga Senior Cntr.
28	Upland	March 10-00	1:00 p.m.	Gibson Senior Center
29	Victorville	March 15-00	2:30 p.m.	Victorville Mobile Home Estates
30	San Bernardino	March 15-00	9:00 a.m.	Public Enterprise Comm. Center
31	San Bernardino	March 15-00	1:30 p.m.	Senior Center Room 103
32	Ontario	March 16-00	1:00 p.m.	Ontario Civic Center Community
33	Wrightwood	March 22-00	11:00 a.m.	Wrightwood Community Room
34	Crestline	March 23-00	1:00 p.m.	San Moritz
35	Chino Hills	March 24-00	9:00 a.m.	Chino Hills Civic Center Comm.
36	Big Bear	March 30-00	10:00 a. m.	Community Room
37	Chino	April. 6-00	9:30 a.m.	Senior Center
38	Montclair	April 6-00	1:00 p.m.	Montclair Community Center
39	Grand Terrace	April 11-00	1:00 p.m.	Community Center

The purpose of the hearings were to identify and assess the needs of senior citizens and younger adults with disabilities as well as to obtain reactions on the present services provided by DAAS and the type of assistance that the older person and younger disabled adults felt were needed. The top four service needs have been detailed in the following section.

Important to note, for the first time in 20 years, the fear of crime and the need for personal safety did not score high. In the past, this was a concern of the older population particularly those living in the metropolitan areas. This stands in sharp contrast with the growing number of elder abuse being reported which increased 5% over the last year. As has been noted by the National Elder Abuse Incidence Study "America's burgeoning elder population has affected every segment of the social, political, and economic landscape. Public debate of the issues surrounding the special needs of the approximately 44 million persons in this country age 60 years and over has heightened national awareness and concern. As a result, public policies relating to issues such as retirement security, affordable long-term care, and quality of life are changing to meet the unique needs of the aging population. Yet, as the public looks toward improving the lives of the elderly, abuse and neglect of elders living in their own homes have gone largely unidentified and unnoticed."[5]

TRANSPORTATION

Transportation is a top concern for seniors and individuals with disabilities. Transportation within the County does not meet the needs of these individuals, as it is often expensive, inaccessible, inconvenient, and poorly or not equipped at all. The present transportation system in some parts of the County provides low fares for specified riders, especially fixed route transportation. This stands in sharp contrast to the high fares charged in other areas of the County.

The transportation services provided within the County in almost all areas are inconvenient for seniors and younger individuals with disabilities. Apart from the high cost, services such as Dial-A Ride and Dial-A-Cab require individuals to call 24 hours in advance in order to schedule transportation. Another major problem with the available transportation services is they do not provide escort services and assistance to seniors and younger disabled adults. One older women stated " I have to book an appointment with Dial-A-Ride a day in advance and then wait up to three hours for the car to arrive." Many individuals need assistance getting in and out of the vehicles. The drivers of the available transportation services do not provide such assistance. Many seniors and younger adults with disabilities also require assistance in ambulating and in interacting with medical providers. They may need help in understanding instructions for medication. They may need transportation from the physician's office to the pharmacy. Transportation services need to be developed which are responsive to the needs of seniors and younger adults with disabilities.

[5] National Elder Abuse Incidence Study prepared by the National Center on Elder Abuse at the American Public Human Services Association* in Collaboration with Westat, Inc.* Formerly the American Public Welfare Association, 1998

The available transportation services do not serve all remote and rural areas of the County. Transportation services in the high desert and mountain communities are not adequate. For example, one elderly women stated "It takes up to three days to get someone to transport me to my doctors appointment…….hope I don't have an emergency I'd never make it." Since emergency medical and other health care facilities are often distant from these rural areas, lack of transportation is a serious dilemma. Individuals may have to wait for hours in order to be transported to receive emergency medical care. Often ambulance services will refuse to transport due to the long distances. Individuals are often referred from one city to another for the services of a medical specialist. One older man stated " There was no transportation available when I cared for my paralyzed mother. The transportation which was available for a short time could not accommodate and elderly paralyzed bedridden person."

Road conditions in some parts of the County are not maintained. According to one older individual, "Public roads are not maintained by the County of San Bernardino which devalues property, rendering it unsellable, left unattended these homes become prime targets for vandalism."

Recommendations

- Develop and expand the TREP program to reimburse volunteer drivers for transporting seniors and younger adults with disabilities.
- Advocate for the development of innovative, creative transportation programs to meet the needs of seniors and younger adults with disabilities.
- Develop contract agreements with paramedic services to work together to meet the needs of seniors and younger adults with disabilities.
- Develop transportation services for seniors and younger individuals with disabilities that are responsive to their transportation needs.
- Encourage cities to utilize their CDBG funds for transportation programs for seniors and younger individuals with disabilities.
- Establish a 24-hour, seven days per week public transportation system in the urban areas.
- Provide affordable transportation to rural residents for necessary medical care.

NUTRITION

The congregate and home delivered senior nutrition program is vital for the growing number of seniors. This program is critical for seniors because it provides nutrition and, more importantly, socialization. It is essential for the nutrition programs to be maintained and expanded in San Bernardino County.

Many communities that are heavily populated by seniors do not have a nutrition site. There are no senior nutrition sites in the mountain communities. The community of Trona, which has over 100 active members in its senior club, does not have a nutrition program. Newberry Springs, Baker, Phelan, Wrightwood, Baker and Chino Hills recently constructed senior centers and have requested to become a nutrition site. Unfortunately, there are no funds with which to expand the program.

A Congregate meals program is also needed to address the growing number of Asian American elderly in the metropolitan San Bernardino area. Congregate and home delivered meals need to be made available to younger adults with disabilities as well. Disabled individuals emphasized they are treated as second-rate citizens. They cannot participate in the home delivered meals program, as the program is clearly limited to person's 60 years and over. They may participate in the senior congregate program if they pay the full cost of the meal of $3.50.

Many seniors report the luncheon meal is what gets them out of the house each morning. Once they are at the site, they find many opportunities for socialization, recreation, and education, not only at the site but other places in the community. The lunch provides a focal point in their lives. Seniors would also like to see improvements in the program in terms of written and consistent policies for all senior nutrition sites regarding operational hours, sign-in procedures, donations, and serving procedures.

The maintenance and expansion of the home delivered meal program is vital to seniors because of the increasing number of seniors who are in need of the service. Seniors are living longer and are living in the

community with more functional impairments than in the past. The program needs to be expanded, as there are many seniors who need home delivered meals but are not receiving them due to inadequate funding.

Recommendations

- ❖ Advocate for increasing the amount of USDA reimbursement, which has been fixed at 53 cents per meal for years.
- ❖ Advocate for increased funding of the Older Americans Act to more adequately provide for the needs of the senior population.
- ❖ Investigate different methods of meal delivery to increase and expand the amount of meals that can be delivered thereby better serving more home bound seniors.
- ❖ Develop media campaigns to encourage senior citizens to participate in nutrition programs.
- ❖ Develop additional funding sources and encourage contractors to seek those funds to provide congregate and home delivered meal programs for younger adults with disabilities.
- ❖ Expand transportation services for seniors and younger adults with disabilities so they may attend congregate nutrition sites and other community activities.

HEALTH CARE

One of the major concerns of San Bernardino County residents is health care. Throughout the County, seniors and younger adults with disabilities agreed that they need access to medical facilities, long-term in-home care, and emergency services. They recognize that improvements need to be made in the provision of medical care to better meet their health care needs. There is a need for more medical facilities and services throughout San Bernardino County, especially in the more rural areas. The access to medical care and services is very limited in many areas of the County and non-existent in others. For example, for one individual living in Trona stated that her provider is across the County line in Kern County, for others along the Colorado River health care services must be secured from providers in Arizona in Bullhead City, Parker, etc Seniors reported having to travel great distances in order to receive the most essential health care.

In addition to medical services, both older individuals and younger adults with mental or physical impairments are distressed about the lack of personal care. There is a major need for affordable in-home care, adult day health care services and adult day care services. These services do not exist or are too expensive for most people. The conditions under which Medicare, Medi-Cal, or other health insurance will provide in-home care or day care are very limited. Another problem is the difficulty in finding trustworthy, reliable people to come into the home and provide the care. As one person stated, “Being visually impaired, I need someone trustworthy to provide basic personal correspondence and help me with reading and filing etc.” The community does not know where to turn to find competent, reliable providers. In the more remote areas of the desert, it becomes even more difficult to find in home care.

The availability and accessibility of emergency services is another issue of concern, especially in the remote areas. Since there is lack of accessibility to such in-County services, residents are often referred to cities in neighboring counties and states. Older individuals and disabled individuals often have to wait several hours for services because emergency medical care providers are so distant. Many of the small towns near the Arizona border experience this problem.

In some areas of San Bernardino County, there are no skilled nursing facilities or residential board and care facilities, while in the more metropolitan areas there are an abundance of skilled nursing beds due to low property costs and readily available low cost labor however, many comments were lodged at the pubic hearings that these facilities needed more aids, more doctors visits, and better food. One individual stated “Better quality food, more variety, and hotter. Facility needs more aids, and doctors do not come enough.”

Recommendations

- Encourage and attract private, for profit and nonprofit organizations to operate skilled nursing care facilities in the more remote communities.
- Provide the full continuum of services, including both acute and community based long term care.

- Encourage senior clubs to develop volunteer programs in which healthy seniors would voluntarily provide services for frail seniors.
- Encourage medical providers and services to establish practices in remote areas by providing government incentives.

HOUSING

Housing issues are a major concern of seniors and younger adults in San Bernardino County. The housing options within the County are limited, many underdeveloped, and although not expensive relative to other areas, they are too expensive for low-income individuals on a fixed income. Most of the available housing tends to be single family housing, which does not necessarily meet the specific needs of seniors and younger individuals with disabilities. Seniors and younger adults with disabilities for the most part live on fixed incomes and are particularly concerned about rental costs and increases. This cost is an important consideration regardless of the type of housing in which they live.

Home repair and home maintenance are other problem areas. Those who own their own homes find it difficult to keep up with basic maintenance as well as major repairs. Money for home maintenance and repairs is a major concern as the cost of labor and materials increase. Since incomes tend to be limited, these populations have difficulty in making even basic maintenance and essential repairs such as gardening, plumbing, and painting.

Mobile home park resident's report feeling more vulnerable to landlords as they do not have the option of leaving. In some cases the resident's need assistance with repairs such as repairing roofs, replacing outdated plumbing, etc. and are ignored by the managers. They want more stringent rent control and regulations placed on the owners of the parks. Mobile home tenants consider they have little, if any control over their living conditions.

Another concern of frail seniors and younger adults with disabilities is the regulations concerning supplemental housing programs. In order to have a live-in care provider, who is often essential to the impaired individuals, there must be a bedroom in which to house the provider. Supplemental Housing regulations such as Section 8 limit the number of bedrooms based on the number of individuals. In order to live in the house the provider must meet the eligibility requirements and the provider's income must be included as part of the total household.

Seniors stressed that a substantial amount of development is needed, particularly for emergency and transitional housing in San Bernardino County. It was emphasized that without emergency housing dependent individuals have to endure abusive situations because they have nowhere else to go.

Recommendations

- Investigate services which locate live-in helper for older or disabled adults to help defray cost and as a possible source of assistance for low-income older persons.
- Advocate for changes in HUD regulations to allow the exclusion of in home care providers.
- Encourage seniors and younger adults with disabilities who are mobile home park residents to use advocacy organizations.
- Encourage seniors and younger adults with disabilities to apply for Section 8 and other supplemental housing programs.
- Maintain local programs to meet emergency housing needs of seniors and younger adults with disabilities.

Targeting

The Department of Aging and Adult Services targets services in three ways:

- By allocating Titles III B, C1 and C2 dollars based on a formula which includes low income, minority, and rural components.

- By contractually requiring service providers to reach the minority elderly in their service areas and by reviewing the monthly reports for each contractor on a quarterly basis to determine compliance with the performance levels.

- By placing whenever possible direct service locations in neighborhoods and communities where the largest number of at risk elderly reside.

Additionally, targeting for the four-year plan has been approached in following way by:

- Reviewing the mandated requirements of the Older Americans Act.

- Reviewing the reports to determine existing service patterns.

- Reviewing census data to determine geographic areas where target populations live.

The Older Americans Act requires the Area Agency on Aging to target services and identify individual eligible for assistance with special emphasis on:

- Older Individuals residing in rural areas.

- Older individuals with greatest economic need (with particular attention to low income minority individuals.)

- Older individuals with greatest social need (with particular attention to low income minority individuals.)

- Older individuals with limited English-speaking ability.

- Older individuals with severe disabilities.

- Older individuals with Alzheimer's disease or related disorders.

The Department of Aging and Adult Services fulfills this mandate in a number of ways. First, the Department monitors the monthly program data to make sure that the contractors are reaching those individuals with the greatest economic and social need. For example, during 1999-2000, which was the last full year of reporting, the Department provided services to:

- 89 Personal Care participants of whom 65% were 75+, 23% were minority, 98% were functionally impaired, and 20% lived alone. Of the minorities served, 70% were low income and 20% of all individuals lived in a rural setting.

- 30 Homemaker participants of whom 90% were 75+, 7% were minority, 17% were functionally impaired, and 80% lived alone. Of the minorities served, 100% were low income and 20% of all individuals lived in a rural setting.

- 20 Chore participants of whom 60% were 75+, 10% were minority, 60% were functionally impaired, and 50% lived alone. Of the minorities served, 100% were low income and 10% of all individuals lived in a rural setting.

- 775 Home Delivered Meals participants of which 4% were 75+, 53% were minority, 76% were functionally impaired, and 46% lived alone. Of the minorities served, 53% were low income and 12% of all individuals lived in a rural setting..

- 15 Adult Day Care participants of whom 53% were 75+, 13% were minority, 67% were functionally impaired, and 13% lived alone. Of the minorities served, 50% were low income and 13% of all individuals lived in a rural setting.

- 4,119 Congregate meals participants of which 64% were 75+, 18% were minority, 52% were functionally impaired, and 41% lived alone. Of the minorities served, 60% were low income and 9% of all individuals lived in a rural setting..

- 143 Transportation clients of whom 30% were 75+, 78% were minority, 0% were functionally impaired, and 65% lived alone. Of the minorities served, 17% were low income and none lived in a rural setting.

- 1,396 Legal Assistance clients of whom 41% were 75+, 33% were minority, 6% were functionally impaired, and 55% lived alone. Of the minorities served, 57% were low income and 19% of all individuals lived in a rural setting.

- 9,599 Information and Assistance participants of which 30% were 75+, 19% were minority, 19% were functionally impaired, and 32% lived alone. Of the minorities served, 78% were low income and 16% of all individuals lived in a rural setting.

- 237 Outreach clients of whom 37% were 75+, 9% were minority, 1% were functionally impaired, and 62% lived alone. Of the minorities served, 25% were low income and 91% of all individuals lived in a rural setting.

- 85 Counseling clients of whom 65% were 75+, 27% were minority, 98% were functionally impaired, and 19% lived alone. Of the minorities served, 70% were low income and 20% of all individuals lived in a rural setting.

- 51 Home and Roommate Matching clients of whom 45% were 75+, 12% were minority, 67% were functionally impaired, and 90% lived alone. Of the minorities served, 100% were low income and 0% of all individuals lived in a rural setting.

- 71 Health Screening clients of whom 11% were 75+, 61% were minority, 0% were functionally impaired, and 14% lived alone. Of the minorities served, 26% were low income and 0% of all individuals lived in a rural setting.

- 42 Home repair clients of whom 36% were 75+, 10% were minority, 0% were functionally impaired, and 93% lived alone. Of the minorities, 100% were low income and 0% of all the individuals lived in a rural setting.

- 27 Medic Alert clients of whom 56% were 75+, 7% were minorities, 93% were functionally impaired and 56% lived alone. Of the minorities, 50% were low income and 0% of all the individuals lived in a rural setting.

- 9,711 In-Home Supportive Services clients of whom 30% were 75+, 18% are minorities, 13% were functionally impaired and 19% live alone. Of the minority 78% were low income and no figures for rural exists.

From an examination of the data, the providers are making every effort to reach the minority and low income individuals.

Finally, the Department plans to target its services by placing service outlets in neighborhoods where large numbers of the target population reside. For example, the East Valley Regional office was located in a second story building downtown where both parking and access were not conducive to seniors. The office which housed the Information and Assistance office, was also located in a poor location to serve the at risk senior population. In preparation for relocating the East Valley office, an analysis of the low income, minority senior populations vs. the overall senior population was prepared to identify possible locations for a future office. Map displays of census tract where 15% or more of the population were seniors, and maps for tracts where seniors who are at or below the poverty level and where 25% of the senior population was minority were also prepared. Based on this information the East Valley Regional office was located in a downtown one story office building which is accessible to both seniors and physically challenged younger adults and has easy access to parking and other important service locations.

As renewals for leases become due, similar analysis will be prepared for the Desert and West Valley Regions, and where possible, offices will be located where they can serve the greatest number of at risk individuals.

Identification of Priorities

The Department of Aging and Adult Service establishes its funding priorities base on the findings of the Needs Assessment, specific targeting issues and adequate proportion of specific services. Increases or decreases in funding are allocated based on this practice.

Information and Assistance serves as a pivot point in the service delivery network. I&A which is a priority service will play an even more important role in the coming year. With the expansion of the Integration project I&A will be a focal point linking older individuals to needed services thus enabling the development of a one stop shop system.

The Integration project will also influence how DAAS prioritizes services. What services will be needed to fill service gaps, to augment, and to allow greater flexibility will be decided during the next four years.

DAAS will continue to fund all the priority services. Increases in funding will be allocated based on formula, best practice and unmet need. Decreases in funding will be treated likewise.